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ABSTRACT

A research design was devised that allowed for the employment of a combination of qualitative and quantitative methods in the collection of data on a group of homosexual men's lay perceptions of Acquired Immune Deficiency Syndrome (AIDS), and those social processes at work in coping with the threat of this terminal disease. The research was carried out by means of the survey procedure as well as participant observation and in-depth and focus group interviews. A total of 1,114 usable questionnaires were returned. Results indicated that AIDS had a very definite impact on the respondents although its influence on their lives varied. Despite the fact that this group of respondents generally had a high level of knowledge of AIDS, some continued to participate in dangerous sexual practices. The reason why some of the men changed their risky sexual behavior and others did not could not be explained only in terms of the causal link that is generally assumed to exist between the provision of knowledge and behavioral change. The assumption that acquisition of knowledge has an immediate influence on the attitudes and behavior of people is thus challenged by the findings of this study. The results of the study reveal the complexity of the psychosocial processes involved in the individual's decision to take or not to take preventive action against AIDS. (Author/LLL)

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AIDS: Lay perceptions of a group of gay men

Evanthe Schurink
W.J. Schurink

Human Sciences Research Council

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EKSERP

'n Navorsingsontwerp wat vir triangulasie (die gekombineerde benutting van kwalitatiewe en kwantitatiewe metodes) voorsiening maak, is opgestel vir die inwin van data oor 'n groep homoseksuele se lekepersepsies van VIGS sowel as oor daardie sosiale prosesse wat gemanifesteer word terwyl die bedreiging van dié terminale siekte die hoof gebied word. Die opnameprosedure is aangevul met kwalitatiewe metodes soos diepte-onderhoude, deelnemende waarneming en groeponderhoude.

Uit die navorsingsbevindings blyk duidelik dat VIGS 'n besliste impak op die respondente gehad het. Die invloed wat VIGS op die respondente se lewens gehad het, varieer egter. Hoewel hierdie groep respondente oor die algemeen 'n hoë mate van kennis van VIGS gehad het, het sommige van hulle steeds voortgegaan om gevaarlike seksuele praktyke te beoefen.

Die rede waarom sommige mans hul seksuele gedrag verander het terwyl ander dit nie gedoen het nie, kon nie slegs verklaar word aan die hand van die oorsaaklike verband wat gewoonlik getrek word tussen die voorsiening van kennis en gedragsverandering nie. Die aanname dat die verkryging van kennis 'n onmiddellike invloed op houdings en gedrag van mense het, word dus deur die bevindings van dié studie betwis.

Die kompleksiteit van psigo-sosiale prosesse betrokke by die individu se besluit om voorsorgmaatreëls teen VIGS te tref al dan nie, word deur die resultate van hierdie studie openbaar. Die belangrikheid van die persepsies van lekelede van teikengroepe wanneer pogings aangewend word om gevaarlike seksuele gebruike te verander, word hierdeur beklemtoon.

Hierdie bevindings hou belangrike implikasies in vir enige strategie wat daarop gemik is om die verspreiding van VIGS te bestry. Aangesien hierdie studie egter slegs verkennend van aard was, moet alle bevindings as voorlopig beskou word. Verdere navorsing rakende leke se persepsies van VIGS behoort onderneem te word ten einde die bruikbaarheid te toets van konstrukte (soos wetenskaplike modelle) wat deur middel van dié studie geïdentifiseer is.

ABSTRACT

A research design was devised that allowed for triangulation (the employment of a combination of qualitative and quantitative methods) in the collection of data on a group of homosexuals' lay perceptions of AIDS and those social processes at work when such people try to cope with the threat of this terminal disease. The research was carried out by means of the survey procedure as well as some qualitative methods which included participant observation and in-depth and focus group interviews.

From the findings of the research it is clear that AIDS had a very definite impact on the respondents although its influence on their lives varied. Despite the fact that this group of respondents generally had a high level of knowledge of AIDS, some continued to participate in dangerous sexual practices.

The reason why some of the men changed their risky sexual behaviour and others did not, could not be explained only in terms of the causal link that is generally assumed to exist between the provision of knowledge and behavioural change. The assumption that acquisition of knowledge has an immediate influence on the attitudes and behaviour of people is thus challenged by the findings of this study.

The results of the study reveal the complexity of the psychosocial processes involved in the individual's decision to take or not to take preventive action against AIDS. They stress the importance of the perceptions of lay members belonging to target groups when attempts are made to change dangerous sexual practices.

These findings have important implications for any strategy aimed at combating the spread of AIDS. However, because of the exploratory nature of the study, the findings remain provisional. More studies of the layman's perceptions of AIDS need to be undertaken to test the usefulness of the constructs (i.e. scientific models) identified in this research.

PREFACE

AIDS has become the modern version of the bubonic plague, the uncontrollable roller coaster of fear and doom that speeds on to leave a path of chaos and destruction behind. Jonathan Mann, director of the World Health Organization, recently voiced the fears of many people when he stated: "Worldwide we believe that we are in danger of losing the war against AIDS." (*Pretoria News* 28/11/1989). An estimated 5 million people have been infected since the first few cases of this fatal disease were diagnosed in 1981 by the Centre of Disease Control in Atlanta. This figure is predicted to rise to 20 million by the year 2000.

AIDS was first diagnosed among gay men, leading the world to believe that only gay people and therefore promiscuous people of low moral standards would be affected. AIDS was labelled "the gay plague" and regarded as a moral issue. Heterosexuals all over the world started playing the blame game. Gays were more than ever stigmatized and ostracized from "normal society". Incited by sensationalist media reports on AIDS victims, calls went up for the incarceration of homosexuals in order to combat the spread of this deadly disease.

Yet despite the fact that the fear of AIDS sent a wave of panic and hysteria through the world, responsible action to prevent this deadly disease was slow to follow. AIDS campaigns were conducted in an even more hysterical and sensational way. The creative minds of marketing researchers came up with the Grim Reaper that stalked its prey in a bowling alley, volcanoes that erupted, gravestones that loomed ominously before crashing down on innocent victims, a gun that was pressed to a human being's head and computer-animated viruses on a mission of destruction dancing gaily through the air.

Some campaigns (of which the one in this country is an unfortunate example) stressed the moral issue and even made a clear distinction between the dangerous lifestyles of so-called promiscuous high-risk groups and those of safe, non-promiscuous, innocent people. This attitude of moral superiority led to the lay belief among most heterosexuals that even if they had an occasional affair, they were not homosexual, promiscuous or addicted to drugs and therefore not susceptible to this disease suffered by these minority groups.

Looking back over numerous AIDS campaigns launched during the past

few years and the millions spent, it becomes clear that despite the fact that people became more aware of this fatal disease, the long-term effects of AIDS campaigning on human behaviour appears to be negligible and society seems to be more confused about the subject of AIDS than it was before campaigning began. What is even worse is that there may be shifts in attitude in the opposite direction to that desired. (Baggaley 1989:42)

It is widely predicted that through the turn of the century HIV infection will continue to spread and more and more deaths resulting from AIDS will occur for years to come (*Population Reports* 1989:3). However the numbers of HIV infections and AIDS cases will vary widely from one region to another. Although homosexuals in the United States of America seem to be the worst affected and at present still account for no less than sixty per cent of the world's AIDS cases, the annual rate of increase is slowing and scientists believe that AIDS has reached its peak among the homosexual populations. Most overseas countries are therefore convinced that the threat of an epidemic has passed. Unfortunately the same cannot be said about Africa, and the rapidly increasing prevalence of HIV infection predicts an even worse scenario for this continent.

In the beginning of 1989 Kenya's health minister, Mwai Kibaki, reported that an average of 200 new cases of AIDS were reported in hospitals in his country every month (*Pretoria News* 16/3/1989). In Uganda AIDS has already claimed 10 000 victims, and 1 million people are estimated to be carriers of this fatal disease (*Pretoria News* 2/12/1989). Zimbabwe reported that more than 10 000 of its inhabitants were tested HIV positive during the first nine months of 1989, and that they had at least 817 AIDS victims in that country, a quarter of whom were children under four years of age (*Pretoria News* 26/7/1989 and 28/9/1989). AIDS figures on the African continent tend to double every six to eight months.

Predictions based on the present prevalence of HIV infected people in the black culture in the Republic of South Africa are unfortunately no more favourable. It is estimated that 40 000 to 60 000 South African blacks between the ages of fifteen and forty have already been infected by the AIDS virus. According to Dr Schall, from the Medical Research Council "a realistic scenario of the development of AIDS in South Africa showed that the disease could halt the population growth of South African blacks by the year 2000 when about 50 per cent of the women and between 30 and 40 per cent of the men would be infected" (*Pretoria News* 1/3/1990).

Projections on the increase of AIDS estimate that by 1993 the treatment of AIDS sufferers could cost South Africa up to R1,32 billion.

It is therefore clear that immediate steps should be taken if a total catastrophe is to be avoided. Since there is no preventive medicine or cure, everything in our power should be done to educate all people with high-risk behaviour. It is of the utmost importance to heed the World Health Organization's warning that the overall effectiveness of any campaign which ignores the importance of lay beliefs and uses impersonal media messages rather than personal networks will be severely limited (Homans & Aggleton 1988:161).

We believe that the scientific value of this book lies in its emphasis on the role that popular health beliefs play in an individual's explanation of the aetiology, transmission and risk of contracting a fatal infection such as Acquired Immuno Deficiency Syndrome (AIDS). Lay beliefs played an important role in explaining the respondents' attitudes and decision whether they regarded themselves as being susceptible to the HIV virus and whether precautions should therefore be taken to avoid contracting the disease.

It is clearly shown that lay beliefs about AIDS not only helped the respondents to cope with the threat of AIDS, but also to make sense of the AIDS phenomenon, features of this fatal disease and events that might befall them. It should be stressed that lay health beliefs are not based on ignorance or misconceptions of medical knowledge, but are deeply imbedded in both the personal biography of the individual who adheres to them, and the cultural and social structures surrounding the individual. It is clear from this study that health beliefs can provide a powerful incentive for changes in sexual behaviour.

This book is aimed at people in the health professions, psychologists, sociologists, social workers and all other people interested in the health field and particularly in AIDS. It is our sincere wish that this study will stimulate our colleagues in the social sciences to urgently join biomedical researchers in their quest to build the puzzle of AIDS into a more comprehensive and understandable picture. If this can be achieved, our efforts and those of the people who shared their intimate worlds with us will not have been in vain.

1

THE DILEMMA OF AIDS

INTRODUCTION

The AIDS pandemic is an unprecedented public health problem facing the entire world. AIDS was first identified in 1981, and by the end of 1989 approximately 198 165 cases had been reported worldwide (*Weekly Epidemiological Record*). According to this report the Americas still has the highest number of reported AIDS cases, namely 131 250, followed by Africa with 36 486 reported cases and Europe with 28 247. Compared to these countries, South Africa has a far lower incidence of AIDS sufferers, namely 305. According to Ijsselmuiden *et al.* (1988:457) it is therefore reasonable to assume that we are now witnessing only the initial stages of the AIDS epidemic.

Numerous attempts have been made to link AIDS to a homosexual or bisexual orientation. This connection appeared to be so clear that AIDS was initially known as Gay-Related Immunodeficiency Disease (GRID), or the "gay plague". The discovery that AIDS is widespread in Central Africa challenged this view and led scientists to realize that at least three distinct epidemiological patterns exist throughout the world (McTigue 1988:92). In terms of the first pattern, which occurs in the United States, most North and South American countries and Europe, the Human Immunodeficiency Virus (HIV) is transmitted predominantly among homosexual men and intravenous drug users. A second pattern occurs in Africa where the infection spreads heterosexually. In Asia, the Middle East and Eastern Europe, where the virus has emerged more recently, a third pattern can be discerned. This pattern is characterized by a low prevalence of infection, even among those with multiple sex partners. Both homosexual and heterosexual transmission occurs, and recent investigations have shown the disease to have spread to intravenous drug users.[1]

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1 A fourth pattern can be identified in Southern Africa where, owing to our unique geographic location, we are not only faced with the Western pattern of AIDS transmission, where homosexual or bisexual men between the ages of 30 and 39 constitute the highest risk group, but also the African pattern where AIDS is transmitted mainly heterosexually.

Although other risk groups have been identified, homosexual men both in the RSA and developed countries overseas have the longest history of AIDS and have suffered the highest fatalities - in fact, they never constitute less than 70% of the annual total of AIDS cases (*Epidemiological Comments,* September 1988:2; Stulberg & Smith 1988:277; Langone 1989:46-48).

Studies of the psychosocial impact of AIDS on the lives of people indicate that it has a profound effect on risk groups already labelled as "deviant" (Batchelor 1984:1279-1284). Gay men appear to be twice jeopardized in that they are at a higher risk of contracting an illness that has become stigmatized as a result of being associated with the homosexual subculture. AIDS reinforces the stereotype of promiscuity and sin held by the broader society towards homosexuals, and thus adds a stigma of immorality to a human disease. As a result of the AIDS scare campaign run by the media, homosexual men worldwide have come to regard themselves as an "endangered species", fearing total extinction not only as a result of a terminal disease, but also as a result of society's attitude (Tatchell 1987:106-122). The fear of discrimination against gays in South African society is clearly expressed in a recent article written by Pegge (1988:109). He states that: "Undoubtedly the greatest impact of AIDS on the South African homosexual population is best described as a prevailing sense of awesome anxiety. There is a great fear that AIDS could be used as a vehicle to foster prejudice and discrimination plus a wide variety of individual reactions."

Several overseas studies have addressed the reaction of the gay community to the threat of AIDS. Virtually all these studies concentrate on the sexual behaviour change of gay men. It is almost unanimously reported that gay men have significantly changed the nature and extent of their sexual behaviour (McKusick *et al.* 1985:493-496; Joseph 1984:1279-1302; Gattozzi 1986:17; Langone 1989:47). However, few systematic studies have been conducted of gay men's knowledge of and attitudes towards AIDS and other factors which may influence behavioural adaptations (Kotarba & Lang 1986; Bolognone & Johnson 1986). The assumption that the AIDS phenomenon has led to dramatic changes in the lifestyle of gay men may thus be premature and exaggerated.

The failure of attempts to prevent AIDS by means of the most powerful communication media has led to the recognition of the immense complexity of human behaviour and has challenged the commonly

accepted (yet scientifically unproven) assumption that knowledge influences attitudes and behaviour (Baggaley 1988). The result has been that renewed emphasis has been placed on the "popular health culture" (Bolognone & Johnson 1986:211) and "common sense" understanding of health and illness that lay persons have (Warwick *et al.* 1988:213; Steyn 1989:3). The Health Belief Model (HBM) originally developed by Rosenstock (1966) and refined by his colleagues (Becker 1974) has become the most influential psychosocial approach towards the understanding of the behavioural, social and cultural factors that together with powerful biological forces have had a bearing on the AIDS epidemic (Kotarba & Lang 1986:131).

The Health Belief Model (HBM) argues that preventive care taken by a person to prevent a particular disease depends on his or her perception and recognition that he or she is personally susceptible and that the particular disease will have severe implications for him or her. The perceived threat of the disease does, however, not provide sufficient impetus for preventive health action since certain modifying dynamics come into play (Becker 1974). These dynamics are of an internal-external nature and include demographic (age, culture), psychosocial (personality, reference group pressure), structural (knowledge of the disease) and supernatural (the will of God) factors.

Notions of personal responsibility for preventive action depend on the individual's perception of the threat posed by the disease once all the above factors have been taken into account. If the threat of the disease remains high and if the individual believes he can still control his/her situation (Pender 1975:387), he or she must still weigh the perceived benefits of preventive action (whether action will eliminate or reduce risk) against the perceived costs (expense, unpleasantness, pain, stigma and trauma). Finally, even if a positive cost-benefit ratio is obtained, the individual requires a "cue for action" stimulus to trigger appropriate health care and preventive action. This stimulus may include mass media campaigns, the illness of a loved one, advice from people important to him or newspaper and magazine articles (Kotarba & Lang 1986:131).

BACKGROUND

Although the Institute for Sociological and Demographic Research

(ISODEM) of the Human Sciences Research Council (HSRC) has studied various aspects of homosexuality (Schurink 1979; Schurink 1981; Schurink & Schurink 1982; Duckitt 1984; Esterhuysen & Minnaar 1985; Schurink & Schurink 1988; Glanz 1988), there is little scientific information on the gay[2] community in Southern Africa. Gays and the gay community in Southern Africa have, however, received increasing public attention during the past few years, and the need for scientific information on gay lifestyles has been emphasized, not only by the general public but also by members of the gay community. In view of this, researchers of the HSRC who had already had contact with leaders in the gay community, saw an ideal opportunity to do a survey among gay men and women in Southern Africa. The survey was planned by a Steering Committee consisting of researchers of ISODEM, leading representatives of the gay collective and the editor of the gay newspaper, *Exit*.

The research was largely shaped by overseas studies and included topics such as the development of a gay identity, sexual behaviour, gay institutions, attitudes towards acts of parliament on homosexuality and health. During the planning stages it became apparent that questions on the threat of AIDS had to be included, as researchers at ISODEM had, since 1986, realized the crucial role that social and behavioural scientists, together with their colleagues in biomedical research, can play in understanding this multifaceted problem. When it later became clear that the early stages of the AIDS epidemic in South Africa reflected the epidemiological pattern of spread mainly among homosexual men, the researchers decided to supplement questions on AIDS in the survey with an in-depth qualitative study of the social dimensions of the AIDS problem among gays in Cape Town.

AIM OF THE STUDY

This report focuses only on matters relating to AIDS. The main aim is to give some understanding of the perceptions of AIDS of a group of laymen

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2 The term "gay" or "gays" will be used when referring to the South African gay community not because the word "homosexual" is necessarily perceived as derogatory by members of the gay collective, but because the term is a self-ascribed label rather than one imposed by outsiders.

considered to be "at risk". An attempt was made to discover and describe their definitions, interpretations and understanding of AIDS, as well as of the strategies employed by individuals and the community to cope with the threat of this major health problem and the stigma attached to it.

METHODOLOGY

For the greater part, the research was done within a quantitative methodological framework supplemented by a qualitative approach. Data were obtained mainly by means of a questionnaire constructed jointly by ISODEM, members of the Gay Alliance (the umbrella body for more than 30 gay organizations) and the editor of *Exit*. It consisted largely of structured questions, but provision was made for a few open-ended questions, the answers to which would reveal subjects' innermost experiences. Respondents were requested to supply additional information by forwarding essays on various aspects of their lives, including their views on AIDS.

In addition to the survey, a qualitative study of the responses of the gay community in Cape Town to the threat of AIDS was initiated by researchers at ISODEM.[3] Data were obtained from gay leaders and counsellors by means of in-depth interviews and participant observation while focus group interviews were conducted with members of the gay community. A single in-depth interview was also conducted with an AIDS victim.

SAMPLING STRATEGIES

An inherent difficulty in researching gay populations lies in obtaining representative samples (Weinberg & Williams 1974; Harry & DeVall 1978; Bell & Weinberg 1978; Batchelor 1984:1279-1284). This is because the prevalence of homosexuality is still shrouded with unknowns because of

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3 The researchers decided to concentrate on GASA-6010 in Cape Town because, at the time of the study, it was the only gay institution to campaign against the spread of AIDS.

homophobia (Schwartz 1987:16) and also because homosexuality, despite its legal liberation, is still regarded as deviant (cf. Albert 1986:167). Although there is scant scientific information on the attitudes of the general South African public towards homosexuality, recent research (Glanz 1988:93-101) has indicated that more than two-thirds of the 1 075 white South African respondents involved in the research opposed the legalization of homosexuality.

The fact that AIDS was first associated with gay men further complicates research into gay communities. "Before the AIDS epidemic 'gay sex' was considered to be against nature - now it is life threatening" (Schwartz 1987:16). The connection between AIDS and the gay population invariably results in an increasing possibility of social stigmatization and oppression. Any research that includes questions on AIDS is thus limited by negative attitudes, behaviour and policies towards a subculture associated with AIDS.

Because the precise number of gays is unknown, researchers have been unable to identify a reliable and valid population for the purpose of sampling, with the result that various methods of sampling have been used.

Methods used include what Babbie (1983) calls "snowball sampling" (Warren 1974; Moses 1978; Troiden 1977), where friendship networks are used as the principal means of gaining access to gay respondents. Other routes into the multifaceted gay community used by researchers include questionnaires that can be distributed, and volunteers for interviews recruited through gay organizations and gay institutions such as bars and gay magazines (Plummer 1981:214).

In gathering the statistical sample for the survey, the Steering Committee decided to use a variety of strategies to gain access to the respondents. A type of postal survey (a magazine-distributed questionnaire - MDQ) currently preferred by social scientists for investigating sensitive social issues (cf. Pratto & Rodman 1987) was used. MDQs are more cost-effective, and sensitive questions can be answered more easily because respondents remain anonymous. Since the research had to be done on a shoestring budget the questionnaire could be compiled only in English. Respondents were, however, invited to contact the researchers if any difficulty was experienced in completing the questionnaires. Altogether 10 000 questionnaires were distributed as a 32 page supplement to *Exit*,

5 000 copies of which were mailed to subscribers. An additional 1 000 were distributed on request, while another 92 were distributed by the researchers while conducting qualitative research in Cape Town. Every questionnaire was accompanied by a prepaid envelope addressed to the HSRC. Since subscribers to *Exit* are generally known in gay circles to be relatively open (overt) about their homosexual orientation, the Steering Committee decided to distribute the remaining questionnaires in additional ways in an attempt to reach gays with a more covert lifestyle. These 4 000 questionnaires were thus distributed at random through gay organizations, gay clubs/bars and gay friendship networks.

Various means were employed to inform the gay community about the study and about the need for people with as many different lifestyles as possible to participate. The survey was advertised in both the September and December 1987 editions of *Exit*. Letters were sent to all gay organizations in Southern Africa with the request to encourage members to participate. Accompanied by leaders in the gay community, one of the researchers visited gay bars and clubs in an attempt to introduce the survey and recruit respondents. Finally, gay leaders and committee members distributed questionnaires among their friends and acquaintances.

A pilot study was conducted in December 1987, and the adapted questionnaire approved, but because of unforeseen circumstances (the disruption of railway services as a result of heavy flooding in certain parts of the country) its distribution took relatively long (from February to June 1988).

The reaction of the gay community was varied, but the response was generally positive. The most important criticism included the following: the HSRC was regarded by some as an extension of the government, some questions were found difficult to answer, completing the questionnaire was time consuming and tiring, female respondents complained that the questionnaire was male oriented and Afrikaans-speaking respondents were offended because the questionnaire was not available in their mother tongue.

In total, 1 114 usable questionnaires were returned, constituting an 11% response rate. Although social scientists appear to differ on the acceptable response rate of mail surveys, it would appear that at least 20 to 30% (Moser & Kalton 1971:268) is regarded as the baseline for responses.

However it should be borne in mind that the response rate of the homosexual community tends to be lower than that of the heterosexual population (Harry & DeVall 1978:25).

Many factors affecting response rates have been identified by social scientists, some of which have already been mentioned. Pratto and Rodman (1987:61-72) justly point out that questionnaires distributed in magazines, and research by means of quota samples, convenience samples and snowball samples suffer from self-selection bias (i.e. accurate data cannot be obtained from all designated respondents). It therefore seems unnecessary to discuss the response rate of the present study in detail, except to mention the most important disadvantage encountered: the fact that *Exit* is a male-oriented newspaper. The percentage of women who read or subscribe to *Exit* is therefore much smaller than the percentage of male readers or subscribers. This is clearly reflected in the sample, since only 9,2% of those who responded were women. As this number (N = 103) is too small for any meaningful statistical calculations, female respondents could not be included in the present report. This is not a major drawback, since gay women are not regarded as a high-risk group for contracting AIDS.

AN OVERVIEW

As was pointed out above, both a quantitative and qualitative strategy were used in the study, thus providing for (a) the statistical establishment of the "sample's" views on the facts pertaining to and causes of AIDS, and (b) the discovery and description of the innermost thoughts of gays on AIDS as well as the strategies they employ in everyday life to cope with the health hazards and the stigma attached to this disease.

Analysis of the quantitative ("hard") data will be discussed in Chapter 7 and the qualitative ("soft") data will be dealt with separately in Chapter 8. An interpretation of all the findings will be presented in Chapter 9. The report will be concluded by Chapter 10, where the most important implications of the research will be highlighted and guidelines toward a comprehensive strategy to curb the AIDS problem will be formulated.

2

QUANTITATIVE DATA

The responses to the relevant questions in the questionnaire used in the survey were coded and quantified,[1] and in order to present an overall picture of the data they will be presented by way of frequency distributions or tables and figures.

In this chapter the following matters will be addressed:

(a) The sociodemographic characteristics of the sample

(b) The sexual behaviour of the respondents and the possible risks regarding AIDS

(c) The gay men's knowledge of AIDS and related matters

(d) The respondents' attitudes towards efforts to combat the spread of this terminal disease and changes in sexual behaviour

(e) The prevalence of certain health and risk factors

SOCIODEMOGRAPHIC CHARACTERISTICS OF THE SAMPLE

The main characteristics of the sample are set out in Table 1. The ages of the respondents varied between 16 and 81, with half being under 35 and 90% under 50 years of age. The majority (94,9%) said they were Caucasian, European or White and 97% could either speak Afrikaans or English or both languages. Nearly 65% had received two years or more training after Std 10 and the largest single percentage (32,2) had received four years or more post-matriculation training. Almost 90% reported that they had never been married, while only 2,9% indicated that they were still married and living with their wives. Eighty-eight per cent indicated that they were economically active; 63,2% considered themselves to be in

1 The open-ended questions will be presented numerically in this chapter, whereas the verbatim responses will be dealt with qualitatively in Chapter 8.

either professional or managerial positions and approximately 60% earned R2 000 and more a month. Most of the respondents (83%) lived in a city in the Transvaal and 69,4% stayed in a house or townhouse. The highest percentage (44,2) lived alone and the second highest percentage (27,0) lived with a lover. More than a quarter of the respondents (29,1) indicated that they either had no church affiliation or were atheists. The largest single percentage (45,1) belonged to a Protestant church and the second largest percentage (11,0) to the Roman Catholic Church. According to the Kinsey Scale (Kinsey *et al.* 1972) almost two-thirds (64,6%) of the respondents could be regarded as exclusively homosexual, while 26,6% were mainly attracted to persons of the same sex, but occasionally also to persons of the opposite sex. On the whole the sample can be regarded as more overt than covert.[2] The largest single percentage (27,6) indicated that they regarded themselves to be very much "out of the closet" and can thus be described as overt-overts (Myrick 1974).

However it should be noted that 41,0% of the respondents had kept their homosexual orientation a secret for relatively long periods of time extending from two years to more than ten years, and 5,1% had not yet disclosed their homosexuality to anyone.

In order to get an idea of the extent of the integration of the respondents into the gay and non-gay worlds, they were asked to indicate whether they belonged to gay and/or non-gay groups. Almost two-fifths (39,4%) belonged to gay groups, while 47,3% belonged to non-gay groups. Although the respondents visited gay institutions (clubs, bars), the gay subculture was not all-important to them.

Thus most of the respondents were white Afrikaans-speaking or English-speaking males aged between 20 and 40 years with a postmatric qualification. Typically they had an exclusively homosexual orientation, were unmarried and were employed as professionals in the higher income strata. They mostly lived on their own in urban areas in the Transvaal and belonged to a Protestant church. They regarded themselves as more overt than covert and although the gay community played an important role in their lives, they were well integrated into both the homosexual and heterosexual worlds.

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2 Gays who follow a covert lifestyle try to keep their sexual identity a secret as opposed to gays who follow an overt (open) gay lifestyle.

The characteristics of this "sample" can, unfortunately, **not** be compared with those of the local universe of male homosexuals because the characteristics of this last category are unknown and, at present, unknowable. It is therefore emphasized that **all the findings discussed later pertain to this "sample" only and cannot be generalized.**

SEXUAL BEHAVIOUR AND RISK FACTORS

First sexual experience

The ages at which the respondents had their first sexual experience are reflected in Figure 1. These ages varied between younger than ten years (22,4%) to 23 years and older (7,0%). The largest single group of respondents (40,1%) was between 11 and 16 years of age when they had their first sexual experience.

Most (65,8%) of the respondents indicated that they had had their first sexual experience with a friend (Table 2). According to the vast majority of the respondents (95,3%) their first sexual experience did not take place against their will.

Involvement in steady relationships

Just over half the respondents (52,4%) indicated that they were not at present involved in a steady relationship (Figure 2). Recalculations of the data showed that, of those presently involved in a steady relationship (N = 471), 3,6% had been involved in such a relationship for less than a month; 20,6% had had a relationship that had lasted between one to eleven months; 21,9% (the largest single percentage) had been involved for one to two years, and almost the same number of respondents had been involved for three to four years (17,2%), for five to nine years (18,9%) and for 10 years and longer (17,8%).

The response to the question "How many relationships have you had with a person of your own sex which have lasted longer than six months?" revealed that a quarter (26,7%) of the respondents had had no such

FIGURE 1 : AGE OF RESPONDENTS' FIRST SEXUAL EXPERIENCE

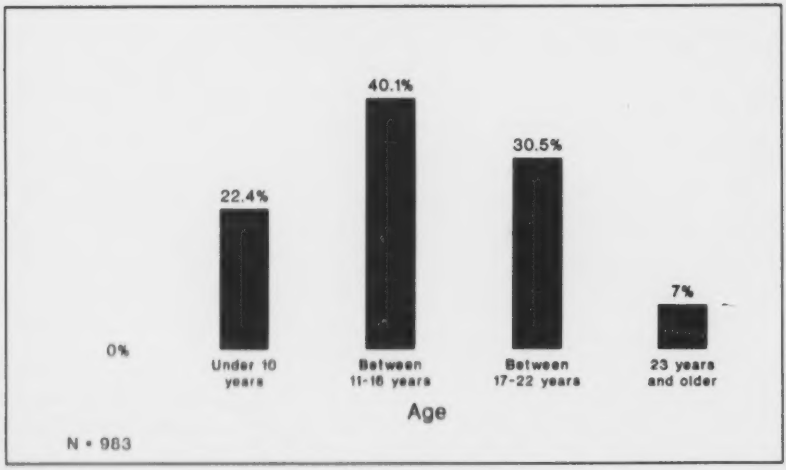
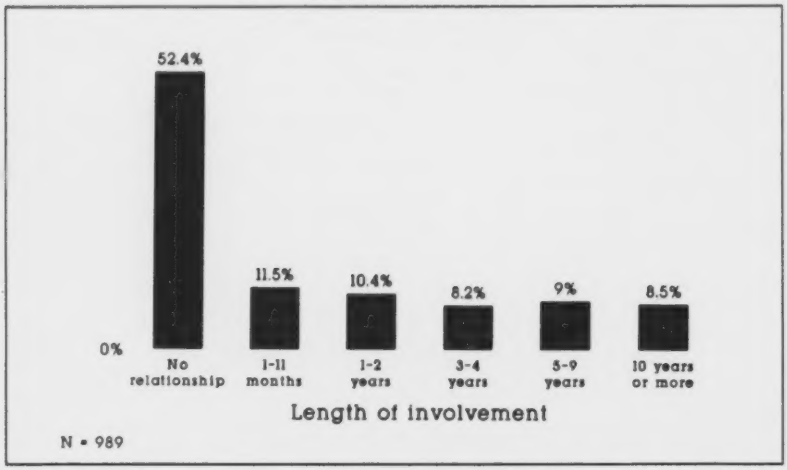


FIGURE 2 : THE RESPONDENTS' INVOLVEMENT IN A STEADY RELATIONSHIP



relationship. Almost half (47,6%) of the respondents had had one to two such relationships and a further 20,3% had had three to four such relationships. The rest (5,3%) had been involved in five or more same-sexed relationships which had lasted longer than six months.

A question was also included to determine the importance of aspects such as a steady relationship, love, sex, friendship, religion and a career in the lives of the respondents. Recalculations of the data indicated that friendship was the most important aspect (98,8%), followed by love (95,9%), a steady relationship (87,3%), sex (84,0%), a career (83,3%) and religion (38,2%).

Involvement in short-term impersonal relationships

The respondents were requested to estimate the number of short-term impersonal relationships with males ("one-night stands") they had had during the past year. The answers varied between none (29,4%) to 51 and more (2,6%). (One respondent claimed to have had 1 000 such "one-night stands".) According to the largest single percentage (40,5) of the respondents, they had had one to five such relationships.

Places visited to meet sexual partner(s)

Thirteen comma five per cent of the respondents denied visiting any of a number of specified places for sexual purposes. From the data in Figure 3 it appears that gay bars (27,7%) were the most popular places for meeting sexual partners, followed by public facilities (15,7%), private gay parties (13,1%), gay clubs (11,6%), shopping arcades/centres (7,8%) and steambaths (4,3%). Gay bars and clubs were however more frequently visited for other purposes (Figure 4) such as to meet new friends, to dance or drink or to take part in competitions.

Sexual practices

The respondents were asked to indicate

(a) which sexual activities they had indulged in;

FIGURE 3 : PLACES VISITED FOR SEXUAL PURPOSES

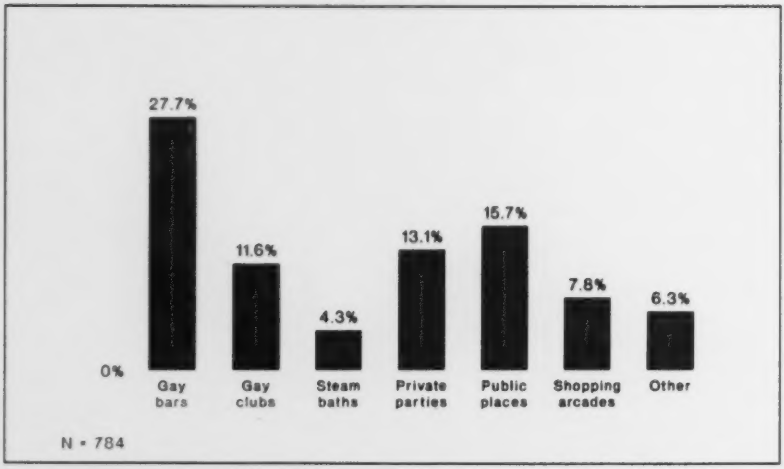
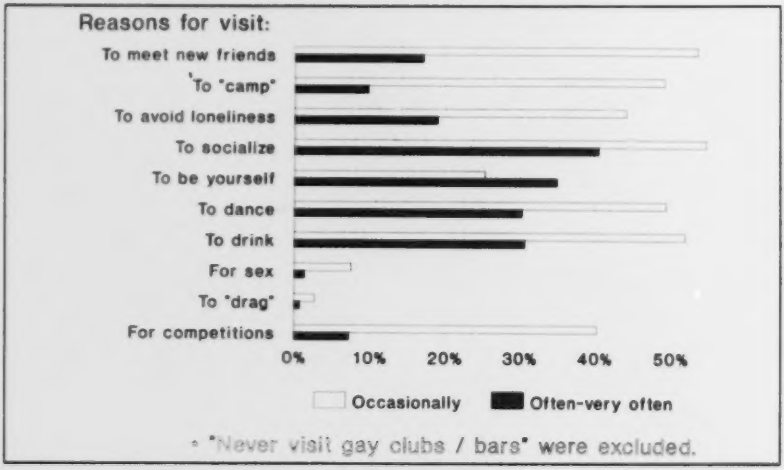


FIGURE 4 : FREQUENCY OF VISITS TO GAY BARS / CLUBS AND REASONS FOR VISIT*



(b) whether they had had regular and/or casual partners;

(c) whether they and/or their partner(s) had made use of a condom;

(d) whether they had taken the active or passive role, and

(e) whether the specific activity had increased, decreased or stayed the same during the 12 months preceding the study.

The responses to these questions are reflected in Table 3.

Active masturbation with a regular partner, active oral sex with a regular partner and active masturbation with a casual partner were reported to be the sexual activities most indulged in by the respondents. Less than half the respondents (43,6%, 45,3% and 47,1% respectively) indicated that they had not participated in these three activities during the preceding year.

Recalculations of the data in Table 3 (omitting those who indicated that they had not participated in the activity concerned) showed that, in decreasing order, the respondents used a condom while participating in the following activities: active anal intercourse with a casual partner (51,0%), passive oral sex with a casual partner (49,8%), passive anal intercourse with a regular partner (30,3%), active anal intercourse with a regular partner (29,7%), active oral sex with a casual partner (18,0%), passive oral sex with a casual partner (15,1%), active masturbation with a casual partner (13,7%), active oral sex with a regular partner (12,0%), passive masturbation with a casual partner (11,7%), passive oral sex with a regular partner (11,2%), active masturbation with a regular partner (10,0%) and passive masturbation with a regular partner (9,4%). Of the 39; 38; 33 and 25 respondents who respectively indicated that they had participated in active "other"[3] activities with regular and casual partners and in passive "other" activities with regular and casual partners, 5; 9; 6 and 5 respectively indicated that they had used a condom.

Leaving those participating in "other" sexual activities aside, it is clear from Table 3 that the activities of those who did not use condoms while participating in any of these activities, decreased rather than increased.

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3 The number of respondents (N = 91) who had participated in these "other" sexual activities was as follows: rimming (8), group sex (7), abstained due to AIDS scare (6), S + M (11), kinky sex (12), body rubbing (30), voyeurism (5), no sex on a regular basis (7) and masturbation (5).

Except for active and passive masturbation with a regular partner, the activities of those who had used a condom during participation in any of the activities concerned also decreased rather than increased. No clear trend is discernible from the responses of the few individuals who indicated that they had participated in "other" sexual activities.

The same set of questions was put to the respondents regarding their sexual activities with females. Only a few[4] respondents indicated that they had participated in such activities. Of those who had participated in such activities, most had participated in active vaginal intercourse with a casual (6,6%) or regular (4,5%) partner.

No fixed pattern in the use of condoms while participating in these activities was, however, discernible.

More than nine out of ten respondents (91,6%) replied in the negative to the question "Do you participate in S + M (sadomasochistic) activities?".

Changes in sexual practices

In order to determine whether any changes had taken place in their sexual behaviour in the recent past, the respondents were requested to describe any changes in their sexual habits as fully as possible. Only eighty-two respondents answered this question. Recalculations of the data indicated that the two main changes in the respondents' sexual practices were that they had had less frequent and/or casual sex (28,0%) and that they had abstained owing either to the AIDS scare or impotency (23,2%).

Influences of the AIDS scare

The AIDS scare clearly influenced the respondents' sexual behaviour. Between 49,8% and 72,2% of the respondents indicated that the AIDS scare had influenced them to

(a) practice "safe sex" (72,2%);

(b) stop visiting certain places for sexual purposes (57,1%), and

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4 Because so few respondents had actually participated in these activities, the data could not be presented in a table format.

(c) to have sex with one exclusive partner (49,8%).

The response to the question regarding the frequency of worry about aspects such as arrest, blackmail, assault and sexual assault, loneliness and AIDS confirmed the influence of the AIDS scare on the lives of gays. Figure 5 clearly indicates that respondents were mostly worried about contracting AIDS (71,1%) and that being lonely (61,0%) (which is generally known as the greatest fear of gay people) was surpassed by the fear of AIDS.

KNOWLEDGE OF AIDS

Quite a number of questions were included in the questionnaire in an attempt to ascertain the respondents' knowledge of AIDS. The first of this group of questions reads: "What do the initials AIDS/VIGS stand for?" Almost four out of every five respondents (79,2%) who answered this question (N = 859) gave the correct answer.

The respondents were also asked to indicate the number of identified AIDS cases that had been reported in South Africa up to the time of the study. The answer options given to them varied in intervals of 10 from between 0-10 to more than 100 cases. The largest single percentage (18,2) indicated that they did not know, while the second largest percentage (17,1) correctly indicated that more than 100 cases had been reported up to that time.

In an attempt to ascertain the respondents' knowledge of AIDS further, they were requested to rate 22 statements concerning AIDS as being true or false. The responses reflected in Table 4 clearly indicate that most of the respondents were well informed regarding the transmission of AIDS. More than 90% knew that AIDS was caused by a virus and transmitted by means of sexual intercourse, blood or blood products (and thus also from sharing needles and syringes) and from a mother to her unborn child. Between 57,8% and 70,0% of the respondents had a good level of knowledge regarding the preventive actions against AIDS, i.e. that all blood donations were tested, and about the diagnoses, prognoses and treatment of the disease. However more than half the sample did not know or doubted whether french kissing could be regarded as a safe practice, whether a water-based lubricant (KY Jelly) was the only lubricant

FIGURE 5 : MATTERS THAT RESPONDENTS WORRIED ABOUT MOST FREQUENTLY

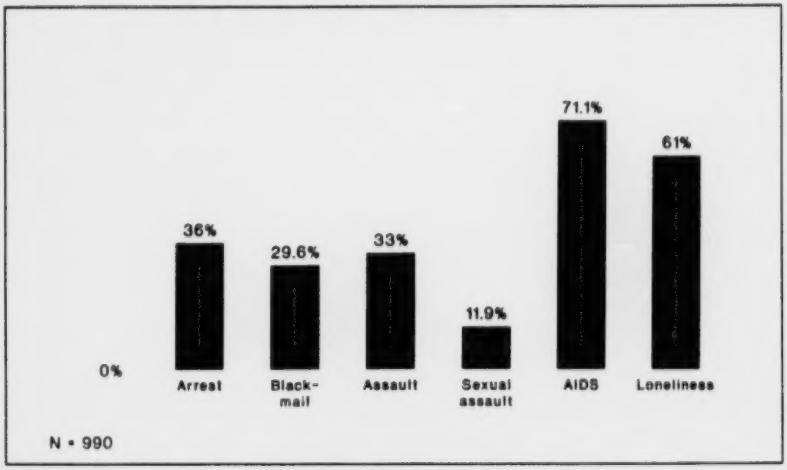
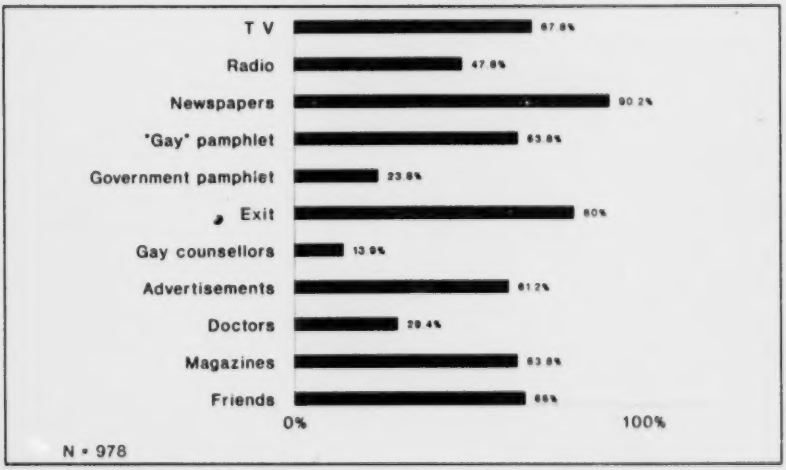


FIGURE 6 : SOURCES OF KNOWLEDGE ON AIDS : "YES" RESPONSES



considered safe when using condoms and that AIDS was not transmitted principally by sexual intercourse between males.

As could be expected 80,2% of the respondents regarded themselves as being well informed about AIDS, while 13,6% replied "No" to this question. Six comma two per cent doubted whether they were well informed. Despite their high level of knowledge on AIDS, 54,2% of the respondents indicated that they felt the need for more information regarding the spread of AIDS. These respondents were requested to specify what type of information they would like to receive. The largest single percentage (29,0) of the respondents specified the need for the latest scientific information and/or regular updates.

The respondents were also requested to indicate how or where they had obtained their knowledge of AIDS and 11 possible sources of information were presented to them. These responses are reflected in Figure 6. It seems as if reports in newspapers were used by the largest single percentage (90,2) of the respondents to gain knowledge on AIDS. This source was followed by *Exit* (the gay newspaper) (80,0%), television (67,8%), friend(s) (66,0%), magazine(s) and gay pamphlets (63,8% each) and advertisements used in the campaign against AIDS (61,2%). One hundred and sixty-eight respondents also mentioned sources such as medical journals (N = 33), overseas campaigns (N = 27), books (N = 21), lectures (N = 19), video tapes (N = 10) and other (N = 58).

In reply to the question "Do you feel your doctor is adequately informed about AIDS?" 49,0% of the respondents answered "Yes", 13,4% "No", while 37,5% indicated that they did not know. Almost two-thirds (64,4%) of the respondents were of the opinion that they could freely speak to their doctors about AIDS. The only matter that a larger percentage (70,5) of the respondents felt they could freely speak to their doctors about, was venereal disease.

Two unstructured questions regarding respondents' knowledge of safe and unsafe sexual practices were posed. Responses to these questions are reflected in Tables 5 and 6, which seem to indicate that the respondents' general knowledge of safe and unsafe sexual practices equalled their high level of knowledge of factors regarding the transmission of the AIDS virus. More than half of the respondents (58,6%) were aware of the fact that mutual masturbation with or without a condom (26,7%), dry kissing (3,6%), body to body rubbing (3,9%), self-

masturbation (12,5%), and sex with one regular partner (11,9%) were considered to be safer sexual practices regarding the spread of AIDS. Anal intercourse seemed to be regarded as a specifically unsafe sexual practice: 10,6% of the sample correctly stated that anal intercourse without a condom was unsafe and a further 30,1% were aware of the fact that anal sex (with or without a condom) could be regarded as an unsafe sexual practice.

Two matters that were emphasized in the respondents' answers were promiscuity and the use of condoms. Any type of sexual practice with one regular partner was considered to be safe by 11,9%, while sex (unspecified) was regarded as a safe practice by nearly 20% of the sample as long as a condom was used. The safety of sex either with a regular partner or with the use of condoms was thus somewhat exaggerated.

It should be noted that some of the sexual practices considered to be safe by respondents could in fact be regarded as very unsafe. These included fisting, oral sex before ejaculation, active anal sex without a condom and French kissing. Cleanliness and body health, swallowing bleach after oral sex, and injecting bleach into the rectum after anal sex were also wrongly regarded by some respondents to be effective measures to prevent AIDS.

The respondents were also asked whether they knew of

(a) government efforts;

(b) gay efforts, and

(c) advertisements in this country to combat the spread of AIDS.

Knowledge of these efforts by the government, by gay groups and through advertisements was reported by 81,3; 79,8 and 82,9% of the respondents respectively, while the rest denied knowledge of such efforts and advertisements.

RESPONDENTS' ATTEMPTS TO DETERMINE AND DIMINISH THE AIDS RISK FOR THEMSELVES AND OTHERS

Forty-one comma one per cent answered the question "Have you taken the so-called AIDS test?" in the affirmative. Those who had not taken the

AIDS test were asked to indicate whether they would be willing to take the test. The majority (42,0%) were willing to take the AIDS test while only a small percentage (11,2) indicated that they would not be willing to take the test and a further 15,1% doubted whether they would be willing to take the test.

The respondents who had not taken the test were requested to indicate why they had not done so. The responses to this question are reflected in Figure 7. The reason given by the largest single percentage (33,9) of the respondents was that they were not at risk. More than a tenth of the respondents also indicated that they were scared about the outcome of the results (15,4%), that they did not know the procedures (14,3%) and that they doubted the confidentiality of the results (13,4%). Three comma six per cent of the respondents who took the blood test acknowledged that the test was positive.

In an attempt to ascertain the risk-taking behaviour of the respondents, they were asked "Thinking back over the past 12 months, how often did you take precautions to avoid the risk of being infected with AIDS when having sex?" Seven comma nine per cent of the respondents stated that they had not had sex during the past 12 months. From Figure 8 it can be deduced that almost a quarter (24,7%) of the respondents always took precautionary measures and a further 23,2% nearly always took such measures, while 15,6% of the respondents never took such measures.

In reply to the question "If you did not take preventive measures (against contracting AIDS), why didn't you?" 689 respondents (68,6%) indicated that they either took preventive measures and/or that they abstained. The reasons given by the rest of the respondents are reflected in Table 7. The largest single percentage (22,7) replied that they had had sex with one exclusive partner for more than ten years. The reasons indicated by 12,6; 13,2 and 19,6% of the respondents respectively, namely that they did not care, that it would not happen to them and that they were not scared, may again be cause for concern. The respondents were also given the opportunity to specify their own reason(s) for not taking preventive measures. The reasons (given by 130 respondents) included the following: exclusive partner (39,2%), heat of the moment/unplanned sexual act (15,4%), lack of information regarding what measures to take (19,4%), no risk of infection/practice safer sex (11,5%), and had been under the influence/reckless (10,0%).

FIGURE 7 : REASONS FOR NOT HAVING TAKEN THE AIDS TEST•

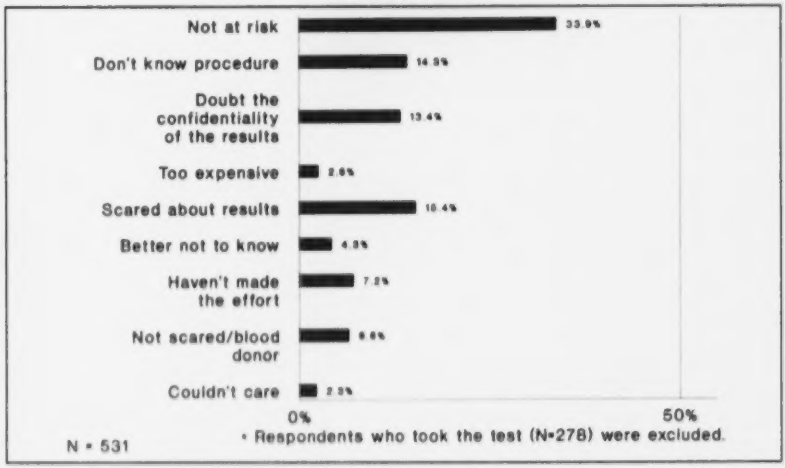
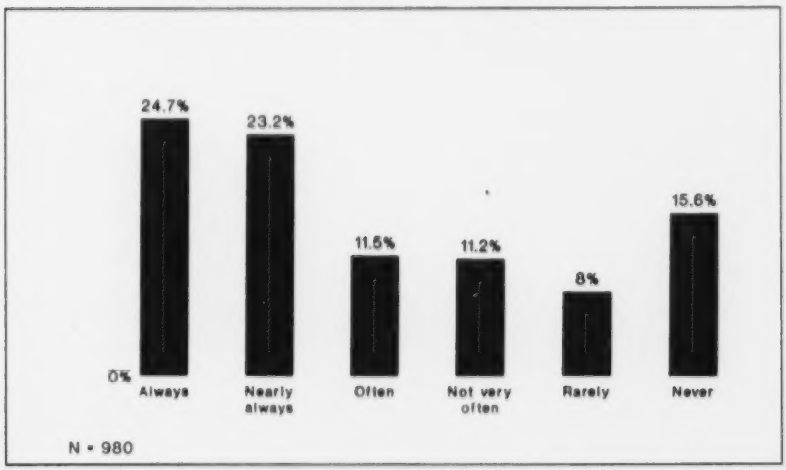


FIGURE 8 : FREQUENCY OF PRECAUTIONARY MEASURES TAKEN BY RESPONDENTS



Those respondents who took precautionary measures were asked to specify these measures. It is noteworthy that 210 respondents (20,9%) indicated that they had not taken such measures. The types of precautionary measures that were taken by the rest of the respondents are reflected in Figure 9. The largest percentage (82,4) indicated that they engaged in only "safe" sexual practices and just over three-quarters (75,9%) indicated that they had fewer sexual partners.

ATTITUDES TOWARD EFFORTS TO COMBAT THE SPREAD OF AIDS, AND CHANGE IN SEXUAL BEHAVIOUR

Efforts to combat the spread of AIDS

The respondents who indicated that they knew about gay efforts (N = 773) and government efforts (N = 803) respectively to combat the spread of AIDS, were requested to estimate the level of effectiveness of both these efforts. Efforts by gay groups were estimated by the largest single percentage (57,4) of respondents to be fairly effective, while a further 13,1% estimated them to be very effective. Only 4,7% thought that these efforts were very ineffective (Figure 10). In comparison, government efforts to combat the spread of AIDS were not highly regarded. Although the largest single percentage (34,0) of the respondents thought these efforts were fairly effective, 31,0% thought they were fairly ineffective and 21,2% thought they were very ineffective (Figure 11).

The respondents who stated that they knew about advertisements used in the AIDS campaign, were asked to describe at most two of these advertisements and to rate their effectiveness on scales ranging from 1 (totally ineffective) to 5 (very effective). The advertisement of Kevin who as a result of his promiscuity contracted AIDS[5] was described by more

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5 This advertisement was financed by the Department of National Health and Population Development.

FIGURE 9 : TYPES OF PRECAUTIONARY MEASURES TAKEN DURING PAST YEAR•

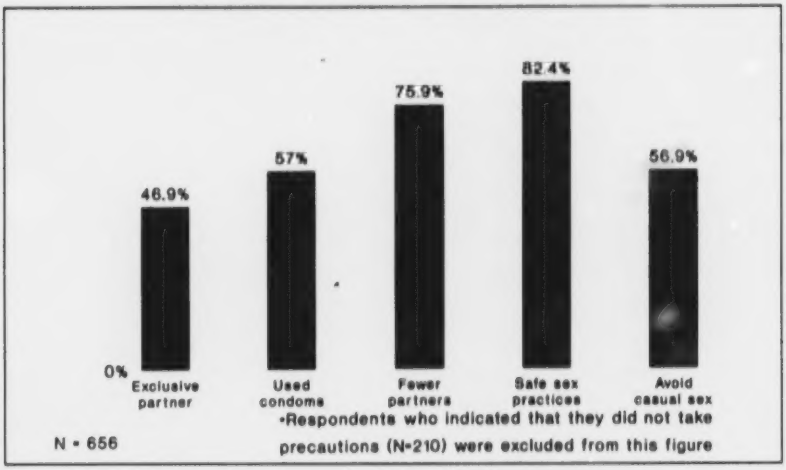
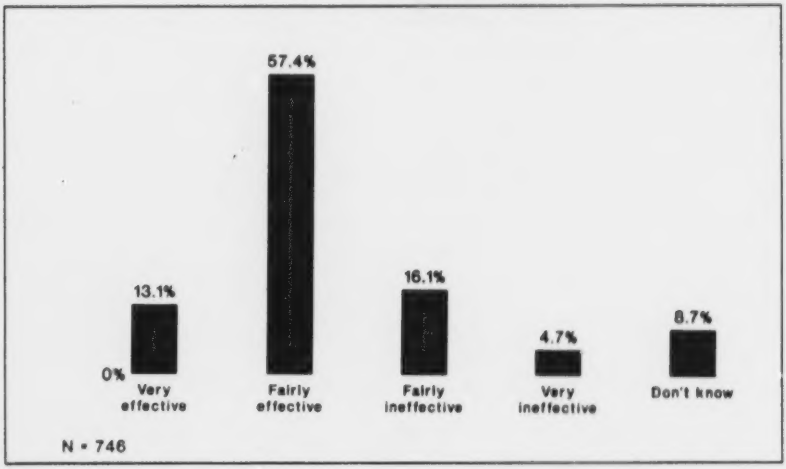


FIGURE 10 : EFFECTIVENESS OF GAY GROUPS' EFFORTS TO COMBAT AIDS



respondents than any of the other advertisements.[6] The ratings given by respondents in general showed that they were more inclined to regard these advertisements as effective (4) or very effective (5) than as ineffective (2) or totally ineffective (1).

Those respondents who thought that government efforts to combat the spread of AIDS were fairly or very ineffective, were asked to give reasons for this view. The reasons are reflected in Table 8. The largest single percentage (23,8) felt that the information provided was insufficient, poor, vague or incorrect, and a further 18,2% would like to see a more open and honest approach. Statements regarding the deficiencies in the government's efforts to combat the spread of AIDS included the following: "They are too plain (inexplicit) - the objective has been drowned by pussy footing bureaucracy"; "They refuse to deal with the main issues"; "They use implicit racism and homophobia in their message which misses the point"; "(It's) a puritan response"; "Fidelity is an ideal but not applicable to the majority (of) both gays and straights (heterosexuals)", and "It is not hard-hitting enough as it is in Europe with billboards, etc.".

Other reasons why the government's efforts were regarded as inadequate centred on the importance of target groups. Nearly 13% (12,7) stated that government strategies did not pertain to all sectors of society and that the AIDS education campaign was incorrectly targeted because it did not take the specific needs of different cultures, subcultures and age groups into consideration.

Further reasons furnished by the respondents as to why they regarded government efforts as ineffective included the following:

- Insufficient funding.
- Lack of consistency in and repetition of the message with resultant confusion and susceptibility to myths surrounding the AIDS phenomenon.
- The moralistic attitude of the government leading straights (heterosexuals) to believe that they were safe because it was a gay disease. That AIDS was a disease of the promiscuous and

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6 Other advertisements described by some respondents included: "Black man dying of AIDS", "Don't bend for a friend", "Girl slept around and now sleeps permanently", "Welcome to the AIDS club", etc.

FIGURE 11 : EFFECTIVENESS OF THE GOVERNMENT'S EFFORTS TO COMBAT AIDS

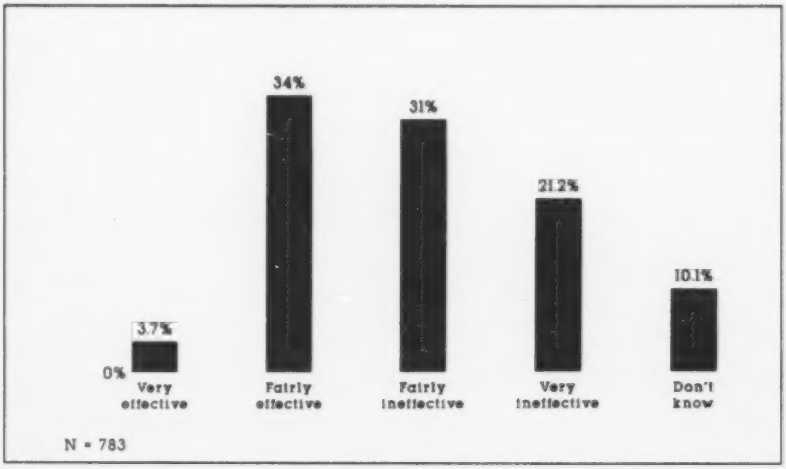
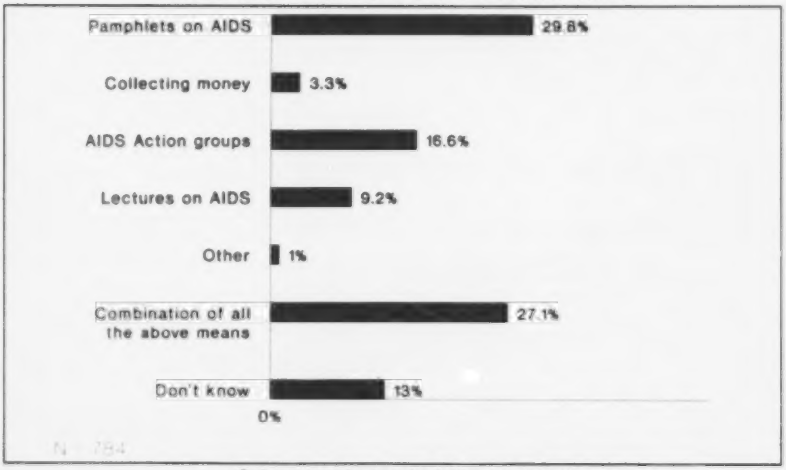


FIGURE 12 : RESPONDENTS' PERCEPTION OF GAY GROUPS' EFFORTS TO COMBAT AIDS •



• Only respondents who indicated that they knew about such efforts were included in this figure

the sinful.

- Lack of a relationship of trust and co-operation between the government and people with high-risk behaviour such as homosexuals and prostitutes to curb the spread of AIDS.

Two questions were asked to elicit the respondents' willingness to participate in efforts to combat the spread of AIDS. In reply to the question concerning whether they would be willing to participate in the campaign launched by the Action Group on AIDS of the Department of National Health and Population Development, 5,8; 60,8 and 33,4% of the respondents respectively indicated that they were already participating and that they would be and would not be willing to participate. Even though more than half (52,2%) the respondents thought the government's efforts were ineffective, they were apparently still prepared to participate in these efforts to combat the spread of AIDS. The respondents were also asked if they would be willing to participate in gay efforts to combat the spread of AIDS. The responses were as follows: "Already participating": 9,8; "Yes": 67,1% and "No": 23,1%.

The responses to the question "Which one of the following means used by gay groups to combat the spread of AIDS are most effective" are reflected in Figure 12. Pamphlet(s) on AIDS were deemed by the largest single percentage (29,8) to be the most effective means. Almost as many respondents (27,1%), though, perceived the most effective means to be a combination of (all or some of) the specified means.

The respondents were asked whether they considered each of 12 specified sources of information on AIDS to be reliable or not (Figure 13). More than nine out of ten respondents indicated that they regarded medical journals (91,8%) and the gay newspaper (*Exit*) (90,1%) to be reliable. In declining order, each of the following sources were also regarded as reliable: gay AIDS Action pamphlets (89,8%), AIDS Action groups (86,2%), their own doctor (79,8%), gay counsellors (76,8%), the information pamphlet of the Department of National Health and Population Development or the government pamphlet (68,6%), television (66,0%), radio (64,8%), advertisements (63,9%), newspapers (62,5%) and magazines (e.g. *Die Huisgenoot*) (42,8%). The mass media (television etc.) thus seemed to be regarded as reliable by smaller percentages of respondents than were the other media. Figure 14 provides a comparison between the sources and the reliability of these sources.

FIGURE 13 : RELIABILITY OF SOURCES OF KNOWLEDGE ON AIDS : "YES" RESPONSES

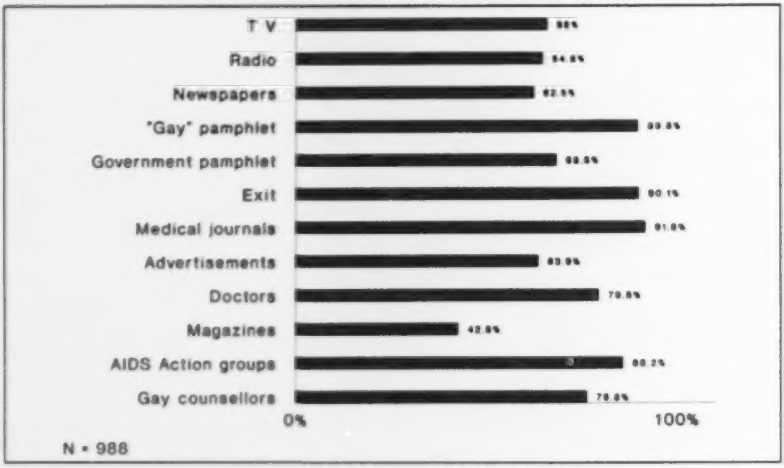
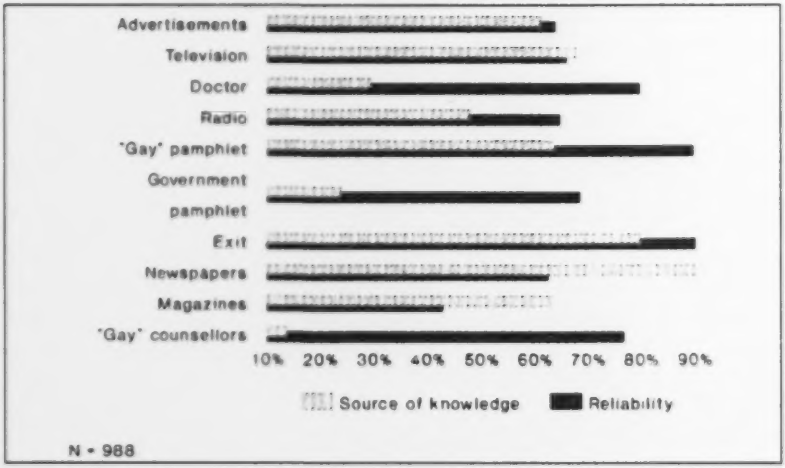


FIGURE 14 : COMPARISON BETWEEN SOURCES AND RELIABILITY OF SPECIFIED SOURCES



Lastly, in this regard, the respondents were asked: "Which of the following means do you think can be used successfully to educate and inform gay people about AIDS?" The responses to this question are reflected in Table 9. Television (94,0%), pamphlets (91,6%) and magazines (90,0%) each received the support of nine out of ten respondents or more. It may be that, even though some respondents did not regard these media (especially magazines) as reliable as some of the others, they thought that these media were relatively easily available to everybody and that they should be utilized to disseminate information.

In addition the respondents were requested to describe three strategies they thought should be followed in order to combat the spread of AIDS. These strategies were classified as follows:

- Continued research to develop a vaccine or cure should be undertaken to solve the AIDS problem.
- More money and means of funding should be made available by the government, churches, public collections, the Chamber of Mines and other vulnerable companies such as those in the life insurance industry which would be influenced directly by the AIDS epidemic through suffering financial loss.
- AIDS victims and persons who were HIV positive should be prohibited, if necessary by law, from spreading the disease and should be counselled on safer sex methods; all black foreigners who were seropositive should be deported, and that all gays should be advised to abstain from all sexual activities.
- Stigma and discriminating practices against homosexuality should be neutralized and legislation against homosexuality, prostitution and pornography should be abolished.
- A comprehensive non-judgemental scientific educational campaign tailored to the needs and level of various target groups and properly funded and sustained should be launched.
- People and bodies who are to convey the message of educational programmes should include the following: the church, the government, properly qualified counsellors and members of target groups, AIDS sufferers, AIDS action groups, doctors, community health workers and public figures such as to top businessmen or pop stars with whom the target group could identify.

- There should be closer co-operation between the government, health bodies and target groups to co-ordinate efforts to combat AIDS.
- The practising of alternative sexual and other safer sex behaviour should be furthered by encouraging monogamy, safer sex practices, the use of condoms and provision of free condoms to those who could not afford them. Other recommendations regarding the practising of alternative and safer sex behaviour included the provision of condom vending machines and of condoms together with single-dose sachets of a waterbased lubricant for the correct use with condoms and "romanticizing" the condom.
- The content of a comprehensive educational strategy and ways through which the message should be conveyed, should include a variety of media such as television, radio, videos, films, newspapers, information pamphlets, photographs and billboards, live plays at theatres and information sessions led by AIDS victims.
- Use available public health care facilities and test the nation's blood banks. Implement compulsory measures, i.e. regular compulsory testing of all sexually active persons; testing all patients who have to undergo operations or who have symptoms of AIDS and testing all migrant workers. People who are not HIV positive should carry cards indicating that they do not have the AIDS virus. Gay clubs and gathering places should be closed down.

Change in sexual behaviour

In an effort to determine which means could be effectively employed to change the respondents' sexual behaviour, they were requested to indicate in respect of each of the 13 specified factors whether the particular factor had influenced them to change their sexual behaviour (i.e. to practise "safe" sex) in order not to contract AIDS. More than seven out of ten respondents stated that they had been influenced by five of these factors, namely newspaper reports on AIDS (77,0%), pamphlets on AIDS (75,9%), articles in magazines on AIDS (74,7%), articles in *Exit* on AIDS

(72,1%) and a television programme(s) on AIDS (71,0%) (Table 10). More than two out of every five respondents (42,8%) stated that they had been influenced to change their sexual behaviour after having learned that someone known to them had AIDS. Replies to the question "Which one of the above possibilities had the greatest influence on you to change your sexual behaviour?" indicated that a personal approach may be the most successful strategy to effect behaviour change since the largest single percentage (18,1) indicated that learning that someone known to them had had AIDS, had had the greatest influence.

HEALTH AND RISK FACTORS

One's health, personal habits and consumption of certain substances can have an indirect, or even a direct, influence on one's behaviour - including one's sexual behaviour. One's sexual behaviour (as well as other risk factors), can also have an influence on AIDS-related risks. A few questions concerning health and risk factors were therefore included in the questionnaire.

As can be seen in Table 11, most of the respondents (51,1%) indicated that they ate three regular meals a day, while the smallest percentage (6,8) described themselves as vegetarians. They seemed to be fairly health conscious, seeing that 46,2 and 44,6% respectively (the second and third largest percentages) said that they regularly saw their doctors for a check-up and that they regularly took vitamins. A third of the sample also indicated that they regularly participated in sport.

The responses to the question "Do you/did you suffer from any of the following?" are reflected in Table 12. Influenza more than once a year seemed to be the most general ailment that respondents had suffered (14,9%) or suffer (10,9%) from. The respondents thus seemed to be in good health.

In reply to the question "Have you ever suffered from any of the following?" just over a fifth (21,7%) of the respondents acknowledged that they had suffered from gonorrhoea (clap). A smaller percentage (5,1) of the respondents indicated that they had suffered from infections of the testes than from any of the other possible infections/diseases (see Table 13).

Of those respondents who engaged in passive sexual practices (receptive anal intercourse) 38,8%; 2,4% and 29,6% respectively acknowledged that they had bled after such intercourse, that they had needed suturing of the rectum after such intercourse and that they suffered from haemorrhoids.

The responses to the question "On average, how frequently do you use any of the following substances?" are reflected in Table 14. Alcohol appeared to be the substance that was consumed most frequently by most of the respondents. Only 5,1% of the respondents indicated that they had never used alcohol, and a further 4,8% indicated that they used to take it but no longer did so. The largest single percentage (42,2) of the respondents indicated that they used alcohol once a week or more (but not daily). Dagga seemed to be the second and "Poppers" (or their equivalent) the third most "popular" substances. Data in Table 14 indicate that these two substances had been at the time used by 31,0 and 24,2% of the respondents respectively. Those who used these substances tended to do so once a year or less frequently.

Regarding the smoking of cigarettes, just over a third (35,4%) and about a fifth (20,3%) of the respondents respectively indicated that they had never smoked, or that they used to smoke but had stopped doing so (Table 15).

STATISTICAL ANALYSES OF SOME OF THE DATA

Although this was essentially an exploratory and descriptive study, it was deemed necessary to analyse the most critical and relevant (pertaining to AIDS) data. It should again be emphasized, however, that the results of these analyses cannot be generalized to all gay men. The results hold true only for the men who participated in the survey.

The fact that AIDS campaigns - according to Baggaley (1988:32-33) - seem to have little effect on human behaviour, challenges the assumption that knowledge influences attitudes and behaviour and that knowledge alone has a direct bearing on people's readiness to take preventive measures. Since an examination of this hypothesis may lead to a rethinking of the means and procedures used to inform and educate people regarding the dangers of AIDS and to persuade them to take precautionary steps, it was decided to test this assumption (as far as it pertains to this specific sample).

Two statistical methods were used and in cases where the dependent variables were categorical, Logit models were fitted. Regression analyses were undertaken in those instances where the dependent variables were continuous. In all the analyses a 5% level of significance was used unless specified to the contrary.

Knowledge of AIDS-related statements

The first question selected for these analyses read: "Please indicate whether each of the following statements concerning AIDS are true or false." A list of 22 statements was presented to the respondents and a "don't know" answer option was also provided (see Table 4). The correct answers to these statements were scaled in order to ascertain the respondents' level of AIDS-related knowledge. The result of this scaling is reflected in Table 16.

As can be deduced from Table 16 the largest single percentage (19,6) of respondents knew the correct answers to 19 out of the 22 statements. The two second largest percentages (18,1 and 15,5) knew the correct answers to 18 and 20 statements respectively. Recalculations of the relevant data show that only a small percentage (3,4) knew the correct answers to half (i.e. 11) or fewer of the statements. The rest of the respondents furnished either between 12 and 17 (35,5%) or between 21 and 22 (7,9%) correct answers to this list of statements. The respondents' knowledge of AIDS could thus be regarded **high** although not perfect.

A number of independent variables were identified in order to determine what factors could possibly have had an influence on the respondents' knowledge of AIDS. They were:

(a) Whether the AIDS scare had influenced them to have sex with one exclusive partner only.

(b) Whether it had influenced them to stop visiting certain places for sexual purposes.

(c) Whether it had influenced them to practise "safe sex" only.

(d) The frequency with which they had taken precautionary measures against contracting AIDS while having sex during the past year.

(e) Whether they regarded themselves as well informed about AIDS.

(f) The number of sources they had used to obtain their knowledge of AIDS.

The first four (a) - (d) variables were included in one model, while the other two variables were taken up in separate models.

Of the first four variables in this model only the respondents' decision to practise "safe sex" related significantly to their knowledge of AIDS. The estimated regression coefficient for the variable "Safe" was 0,2950. This means that the group that did practise "safe sex" (who replied "Yes" to the question) scored on average 0,3 points above the average for the two groups on the "Knowledge" scale, whereas the other group scored on average 0,3 points below this average. The difference between the two groups is not considerable though, being only 0,6 points.

There was also a significant relationship between the fifth variable (e) and the respondents' knowledge of AIDS. The estimated regression coefficient for those who considered themselves well-informed about AIDS was 1,4354, and -0,5798 for those who thought they were not well-informed. For those who doubted whether they were well-informed the regression coefficient was -0,8557. The group that regarded themselves as well-informed thus scored on average 1,4 points above the average for the three groups, while the other group scored on average 0,6 points below this average score.

The last of the six variables (see Figure 7) was first of all scaled to ascertain the number of sources used by the respondents to obtain their knowledge of AIDS. From Table 17 it is clear that the largest single percentage (19,4) had utilized five of the 11 possible sources. More than one-tenth in each case also indicated that they had utilized six (18,0%), seven (15,1%), eight (12,7%) and four (11,6%) of the 11 listed sources. Eleven comma two per cent had thus utilized three or fewer sources, whereas the remainder (12,0%) had used nine or more of the sources.

The correlation between the two scales (number of sources utilized and level of knowledge of AIDS) was 0,13284235. This means that the more sources utilized, the higher was the respondents' level of knowledge of AIDS.

The relation between certain aspects of sexual behaviour and the respondents' knowledge of AIDS

The respondents' level of knowledge in respect of various AIDS-related statements, as reflected in the knowledge scale (see Table 16), was divided into three categories. Category 1 represented the lowest level of knowledge, Category 2 the second lowest level of knowledge, and Category 3 the highest level of knowledge. In order to determine the possible influence of the three levels of knowledge on various aspects of the respondents' sexual behaviour, the following dependent variables were used:

- Frequency of taking precautionary measures
- Number of short-term relationships
- Sexual activities
- Number of past relationships lasting longer than six months
- Places visited to meet sexual partners

The first question selected as a dependent variable read: "Thinking back over the last twelve months, how often did you take precautions to avoid the risk of being infected with AIDS when having sex?" Since this variable was categorical, Logit models were fitted. Three variables were included in these models, namely:

(a) Length of involvement (at the time of the study) in a steady relationship.

(b) The respondents' knowledge of AIDS (see Tables 4 and 16).

(c) The church/denomination to which the respondents belonged.

None of these variables appeared to reveal a significant relationship with the dependent variable (taking of precautionary measures). Of particular importance is the fact that the respondents' knowledge of AIDS (which was generally high) did not show any significant relationship with their taking of precautionary measures. It should also be noted that no significant relationship between the length of respondents' steady relationships and their taking of precautionary measures could be found.

The second question selected as a dependent variable read: "Estimate the number of short-term impersonal relationships ('one-night stands') you had during the past year." Regression analysis was used because of the continuous nature of the dependent variable. Only one variable was included in this model, namely the respondents' knowledge of AIDS. The relationship between knowledge and the number of short-term relationships was not significant at a 5% level but it was at a 10% level.

Another aspect of sexual behaviour chosen as a dependent variable was the sexual activities the respondents engaged in with casual partners. A Logit model was used. Only one type of sexual practice, masturbation (which is generally regarded as a "safer sex practice"), showed a significant relationship with the participants' level of knowledge. Thus the higher the level of the respondents' knowledge, the less likely they were to participate in active or passive masturbation with casual partners. The relationship between the respondents' level of knowledge and their participation in active and passive oral and anal sex with casual partners (which are generally regarded as unsafe sexual practices) was not statistically significant.

Another question selected as a dependent variable read: "How many relationships have you had with a partner of your own sex which lasted longer than 6 months?" No statistically significant relationship was found between the respondents' level of knowledge and the number of past relationships they had had. A further item chosen as a dependent variable was the places visited by respondents to meet their sexual partners. A log-linear model was used. The probability was the highest for members of all three categories of knowledge that they would meet their sexual partners at gay bars. The second highest probability (for all three categories) was public facilities (e.g. toilets, parks and shopping arcades). The third highest probability was private gay parties while the second lowest probability was gay clubs. The probability was the lowest for members of all three categories that they would meet their sexual partners at gay functions. A significant relationship was found between "knowledge" and "place". The probability that they would meet sexual partners at public facilities (which are generally regarded as picking-up venues for impersonal sex) decreased as the respondents' knowledge of AIDS increased. The probability that members of Category 1 would meet sexual partners at public facilities was 0,32 compared to 0,31 for Category 2 and 0,27 for Category 3. The probability that they would meet sexual

partners at private gay parties (which are generally regarded as more sophisticated venues for meeting other gays) was higher for members of Categories 2 and 3 (0,21 and 0,19 respectively) than it was for members of Category 1 (0,12).

Long-term permanent relationships and the frequency of short-term impersonal relationships

Another aspect of the respondents' sexual behaviour that was considered important was the frequency of participation in short-term casual relationships by respondents who stated that they were engaged in permanent long-term relationships with one partner (at the time of the study). Regression analysis was used. Permanent long-term relationships were divided into two categories: relationships lasting less than one year (Category 1) and relationships lasting one year and longer (Category 2).

The regression coefficient for the variable "long-term relationships" was 2,9555. This means that the respondents in Category 1 scored on average 2,956 points above the average number of short-term relationships with casual partners, while the respondents in Category 2 scored on average 2,956 points below the average. This in turn means that respondents who were involved in a long-term relationship with one partner could also be involved in additional short-term relationships. However the longer the long-term relationship had lasted the less the respondents were inclined to engage in short-term relationships with casual partners.

Inference

Although knowledge of AIDS appeared to have some influence on certain aspects of the respondents' sexual behaviour, they still (regardless of their level of knowledge of AIDS) participated in dangerous sexual behaviour. Since a significant relationship could not be found between the respondents' level of knowledge and all categories of their sexual behaviour, it can be concluded that knowledge alone did not influence their sexual behaviour.

3
QUALITATIVE DATA

The qualitative methods employed in this study included in-depth unstructured interviews, focus group interviews and documents (e.g. essays written by subjects at the request of the researchers and circulars, brochures, etc. used by gay organizations). These methods generated a massive volume of "soft" data. The detailed descriptions of gays' experiences, attitudes, behaviour patterns, beliefs and thoughts were broken down into manageable units and classified according to concepts and interpretations of situations they **themselves** used.

In this section the data are presented according to the method by which they were obtained and by means of verbatim excerpts. Only the clearest and most representative excerpts are presented. In certain cases, however, the excerpts had to be edited or paraphrased for the sake of brevity.

INSIGHTS OBTAINED BY IN-DEPTH INTERVIEWS

In-depth interviews conducted with gays in Cape Town yielded valuable data on gays' perception of AIDS and related matters, as well as on the action taken by a voluntary gay organization to curb the spread of the disease.

Perceptions of AIDS and related matters

The following are views gleaned from in-depth interviews:

The gay plague view

> It is probably too late to contain the spread of AIDS in the gay population in South Africa. It is probably too late because it has already seeped through into the less

promiscuous members of the community and it is going to spread simply because when you get to know somebody - and this is due to media distortion ..... The media has conveyed the impression that AIDS is the disease of the promiscuous, the sleep-arounds and the people of low moral standards. It is the stereotype conflict for the person going down with AIDS, simply because when he looks at himself (and when) he looks at his partner he does not see a promiscuous sleep-around. He sees somebody who is like him, who has got a stable job, who has a nice family background and all the nice things. How can this person be a carrier of AIDS? So you have got the conflict ... (Interview with J.: 1988-02-04).

Dan is dit skokkend dat onder ons redelik ingeligte mense, ... bestaan daar mense wat werklik beter behoort te weet, nog heeltemal die gedagte van dis 'n gay-plaag. Nou bestaan die idee dat: "Ons gaan dit nou beperk deur byvoorbeeld streng maatreëls toe te pas ten opsigte van ongetroude mans bo 25 jaar, dan is ons veilig." Ek dink daar is opsetlike ontkenning, opsetlik 'n soort van houding: "Dis iets wat tuishoort by die gay-gemeenskap, dis deel van daardie bepaalde lewenstyl en dit is hulle soort van gevaar ook ..." Een van die onderliggende implikasies is dat daar nou 'n algemene vrees kan kom dat AIDS aangewend kan word om vooroordeel en diskriminasie te bewerkstellig (Interview with E.: 1988-01-21).

I think that we have the idea that it is very much confined to the homosexual population and blacks. Two groups who have traditionally been stigmatized in society. There is not much interest, I don't think amongst heterosexuals there is fear but I don't know whether there is an awareness that we must actually do something (Interview with L.: 1988-02-04).

Stigmatization of HIV seropositive individuals and AIDS patients

One problem with AIDS is (that) people who have it are probably the most stigmatized persons in Western society today. Therefore they do not want other people to know that

they've got AIDS. That again is fundamentally wrong in prevention. People should know people who have AIDS. Again we can go back to the media. The media has contributed enormously to stigmatization of AIDS persons and therefore it is directly responsible for preventing sound, proper and timeous knowledge to prevent the disease ... I think the damage has been done, the perception is that it is a gay disease and a black disease and the attitude and the behaviour will only change when we come to know people with AIDS (Interview with J.: 1988-02-04).

Dan is dit so as 'n mens dink aan wat die spesifieke gevolge vir die slagoffer moet wees ... Baie negatiewe gevolge, daar is sosiale verwerping selfs by 'n positiewe toets, sou dit bekend word, dit is nou behalwe gevolge wat ekonomies is soos werkverlies. Dan moet daar staat gemaak word op 'n geringe ongeskiktheidspensioen. Dan ook isolasie. Isolasie is die tragieste, om nie te praat van self-isolasie nie. Dit gaan ook daarmee gepaard. Dit gebeur baie dat gay-mense nie "uitgekom" het nie en nou skielik dwing hierdie siekte, hierdie ding jou "uit". Daar is mense wat dood is in hospitale aan AIDS wie se ouers nie eens weet dat hulle AIDS gehad het nie, wat dit nie wil erken nie. Sou ouers dit wel agterkom het ons gevalle gehad waar hulle daardie persoon totaal verwerp want hulle sit verstaanbaar nou met 'n krisis op hande, 'n "coming-out" is vir die ouers net so 'n groot skok as vir die kind self ... Nou moet die ouers skielik daarmee gekonfronteer word. Die persoon met AIDS, vir hom is dit nog baie erger want nou sit jy nog met 'n dodelike siekte ook nog, en hulle weet hulle moet van jou afskeid neem ook nog. Dit is 'n moeilike ding (Interview with E.: 1988-02-21).

HIV positives lead very dangerous and lonely lives because they do not share the information with anybody that they are HIV antibody positive. There are plenty of cases of people who have done so and lost their friends overnight, had their jobs in jeopardy overnight - it is not worth sharing. So it is a desperately lonely experience (Interview with J.: 1988-02-04).

The term "high-risk group" and people at risk of AIDS infection

> I find the term (high-risk group) very oppressive. I don't think it makes any sense. I think you get high-risk behaviour. To say that homosexuals are a high-risk group is absolute nonsense because you get lots of homosexual people who are in relationships, who don't practise promiscuous sex practice in any way whatsoever and who are very careful about what they do and (they) engage in sexual activity that is completely risk free. So to talk about homosexuals being a high-risk group I think is a total misnomer. Yes, homosexual people happen to be one of the groups that have been most affected but it does not make them a high-risk group. It is human beings who get AIDS ... It is the behaviour that you are trying to alter, be it with prostitutes, or with drug addicts or with homosexuals, or with heterosexuals. It is the behaviour that causes the transmission of the virus, not the person (Interview with L.: 1988-02-09).

> There is your AIDS danger. Because the moment you are in a relationship whether it lasts two weeks or six months you normally get people engaging in the full spectrum of sexual behaviour. There is your highest AIDS risk. Particularly if anal intercourse is engaged in, because you are getting repetitive infections ... If we take a look at our incidence here in Cape Town of those who have died of AIDS and were known to this counselling service: So far the majority trace their source of infection to a relationship which they have had no difficulty in identifying. We are not seeing the casual one-night standers and this clinical experience is vital in designing effective prevention strategies for gay persons. Safer sex must be the norm, even in relationships until both partners have tested negative after one year (Interview with J.: 1988-02-04).

> 'n Onrusbarende hoë aantal (AIDS-gevalle) is mense wat as 'n reël nie losbandig was nie, maar dat dit mense is wat vir 'n lang tyd in 'n verhouding was en daar het struweling gekom of daar was spanning en nou breek die persoon uit en is

onverantwoordelik. Ek dink jou persoon wat redelik seksueel aktief is maar dit veilig doen, het minder risiko as hierdie een wat na 'n struweling uitbreek, want wanneer hy uitbreek dan breek hy totaal onverantwoordelik uit en hy neem nie maatreëls nie want hy is nie gewoond om in die verhouding veiligheidsmaatreëls te tref nie (Interview with E.: 1988-01-21).

I would say there is a lot of people that I have come across who really don't give a damn - who just think - well, if I am going to get it, I'm going to get it, so what? They have no idea in this country of the absolute horror of AIDS (Interview with L.: 1988-02-09).

Rents are very much a danger, I should think they take no precautions at all and they are a danger in violence as well. They are very mixed-up, a person who is really gay and he does gay things for money ... Professional men have been beaten up and murdered in Cape Town ... I think people like that if they get AIDS will try to spread it deliberately in order to get back at society (Interview with D.: 1988-02-05).

There are also other AIDS issues and I don't know if I am talking out of turn here but what about our South African soldiers who are going up into Namibia and who are sleeping with prostitutes there? ... They are coming back here having relationships with wives and girlfriends (Interview with L.: 1988-02-09).

The impact of AIDS on the gay community

Suddenly AIDS came on the scene. I think gay people more than others perhaps behaved like heterosexuals today, and said: "We don't want to know about this problem we want to bury our heads in the sand, it would be much more comfortable that way" ... Then we started getting our first AIDS patients and this is also fundamental about AIDS - you really get cracking when you know somebody who has got AIDS ... The fundamental shift in behaviour is only going to take place when we know people who have AIDS (Interview

with J.: 1988-02-04).

The facts have long been known that the media sees AIDS as a lovely thing to sell newspapers. "Dit is 'n skandaal", and what's more it only affects unimportant groups - gays and blacks. That is the media perception. Go to town, make your "skinder and skandaal" - after all the lives that it is affecting are not important (Interview with J.: 1988-02-04).

The psychological impact of HIV testing is enormous. We must remember why the test was created. The test was developed to protect the blood supply ... It wasn't invented to give life insurance the reasons not to provide life insurance. It wasn't developed to destroy people's worlds. It wasn't developed for all sorts of reasons it is being used for. It was mainly developed to protect the blood supply and to diagnose AIDS when you are sick. When somebody comes in with recurrent infections, strange pneumonias, etc., then the doctor has the right and the proper use of the tests. Test then to exclude AIDS or confirm AIDS. The AIDS test has given to mankind probably the most weird scientific creation the medical world has ever faced and that is the power to psychosocially destroy somebody probably seven years before he gets ill, if he gets ill (Interview with J.: 1988-02-04).

Ja, hulpeloosheid, die veld wat so braak lê, is so groot om almal te probeer bereik en om dit objektief te probeer doen; jou groot storie is geld. Miljoene wat ter sprake kom as 'n mens wil deurbreek deur al die vooroordele - ook onder jou gay-gemeenskap. Ons het begin deur byvoorbeeld redelike eksplisiete dinge te sê, deur 'n ding by sy naam te noem, deur nie sagte woorde te gebruik nie ... en die reaksie gekry van gay-mense: "Nee, julle moet nie so vulgêr wees nie!" Maar dit is waaroor dit gaan (Interview with E.: 1988-01-21).

Putting across safer sex as the only alternative. We started off ... initially it was just ordinary little pamphlets with a bit of information just alerting people to the dangers, but then the newspapers were carrying very much scary stories, the fact that it was a gay plague and it was very difficult. We weren't

very well received. People thought we were exaggerating and that we were hysterical so initially while they were taking pamphlets there was a lot of resistance. They said, we were overreacting we weren't really offering them something valid. Then when there was more sensible publicity, there was a lot more support, it became easier for us to hand out pamphlets. Right from the beginning we started with the policy of handing to people in these places (where gays gather). Being aware all the time that our handouts were very limited. We weren't reaching coloured people in Cape Town. Only the ones that were at the club, and they represented very much the screaming queen population. So it was limited, but we felt that we had to start somewhere and we had to reach the people we could and that's how it all started (Interview with L.: 1988-02-09).

Yes, gays have certain stereotype ideas about AIDS. In the first place the attitude of because I am not promiscuous - which by the way means different things to different people - I can't get it. Because I don't sleep around I am quite safe. I don't do anything wrong ... I am prepared to take the chance. I am careful about whom I sleep with, they look okay. I only meet them in certain places. Therefore they are fine. So there are those kinds of ideas. If you meet the right person you are okay - the two of you can do what you like - it is all fine (Interview with L.: 1988-02-09).

Strategies and recommendations for combating AIDS

Die groot aksie in hierdie stadium was nog een van ontkenning gewees ... Dit was lank ontken dat dit op die myne bestaan, dat dit ontstaan by arbeiders uit Malawi. Dit is lank ontken dat dit onder prostitute in Zimbabwe en gevaarlik in Suid-Afrika en Angola bestaan en dat dit daar besonder hoog is, al die kliënte daar - die Weermag en Polisie - dis onder dekmantel. Verder word dit nou nog ontken dat dit gevaarlike afmetings onder plaasarbeiders in Natal aanneem. Dit is vir 'n lang tyd oor die boeg van 'n gay-plaag gegooi - dit is alles deel van die ontkenningstorie ...

Die benadering is een van ontkenning, dis een van dit raak my nie. Dit sal miskien anders wees as die situasie begin ontwikkel waar kabinetministers se dogters en seuns daaraan begin ly (Interview with E.: 1988-01-21).

It's totally negative to do nothing ... Whatever we can do on our side I think should be aimed rather on us gays trying to educate the gay people into safer sex use responsible habits ... As far as the government is concerned they are aiming the advertising campaign at the heterosexual side of the community ... Nothing that the government does is totally accepted by the whole population. They discount anything so it's probably going to flop unless they speak to the coloured population and the blacks in their own terms and on their cultural level they will accept. I don't know how to do it so I can't blame the government for not knowing to do it ... (Interview with D.: 1988-02-11).

I think this is where the government made a tremendous mistake in that they have spent a million rands on an advertising campaign, which is all very glossy and all the rest of it, but it doesn't make sense because it doesn't get to particular target groups and they keep telling us that the high risk individuals are the people that practise high-risk activity, homosexual men, prostitutes, drug takers and then the heterosexuals get the advertising campaign, it is aimed directly at the heterosexual. So it doesn't make any sense (Interview with L.: 1988-02-09).

In the Government Gazette of 30 October AIDS was made a communicable disease, alongside typhoid and malaria. I think it was wrong. I don't think it is a communicable disease in that sense. You cannot get AIDS by being with someone who has AIDS ... I don't think it should be that or a notifiable disease. I think one has got to go for a positive view, rather educate, provide information and services to people. Get information across to as many people as possible. Educate people in the work place and I think here we need some legal clarity on: can persons be fired from their jobs simply because they have been tested? Can persons be fired because they are positive? What is the position when

somebody has AIDS? Is that grounds for dismissal? At that point is a person considered to be incapable of carrying on with their work? At the moment I don't think you have any rights and the whole question is confidentiality (Interview with L.: 1988-02-09).

Education is our only answer: making AIDS human. AIDS is a human disease, it affects human beings - that is not appreciated ... You know in South Africa we love putting people into little boxes either racial boxes, religious boxes or conservative boxes or liberal boxes or whatever it is. We forget people with AIDS are human beings. The major task I think in South Africa is not going to be education of the gay community which can be easily undertaken using what is done in other Western countries. The problem is going to be educating our black community especially when it comes to the use of condoms (Interview with J.: 1988-02-09).

Miskien net ter inligting wat betref die benadering van amptelike instellings (teenoor homoseksuele) wat daar op die oomblik bestaan vir navorsing, ook vir ondersteuning ens. en dan die AIDS Advisory Commission. Ek weet van 'n besondere bekwame persoon wat van onskatbare waarde sou wees op daardie amptelike raad en wat voorgestel was daarvoor en nié 'n lid geword het nie omdat dit uitgelek het dat hy gay is (Interview with E.: 1988-01-21).

I think one has to get the message across what AIDS is. How it is transmitted and how to prevent it. I think those are the three main issues. It is a virus that causes the disease, not homosexuals or whatever. The facts about how you can go about preventing it and to avoid the pitfalls that they had in Britain, where they scared people. Apparently the education was effective, but also very detrimental because they scared people too much - so you had a lot of fear and a lot of uncertainty. I think you have got to provide people with information because informed people are people who can make sensible and hopefully responsible choices about what they do, and they must open up the possibility that if people do want to talk to somebody they can approach a service ... I think Britain is perhaps one of the places which can teach

> us a lot. I know that they have top magazines specializing for the 12-18 age group where they had special information for drug users, for sexually active teenagers. Very straightforward messages: "AIDS is not only for gay people. This is what you can do - use a condom this way - phone this number if you need more help." Very clear very simple but aimed at a specific market and I think that was very effective. They also send out stuff to every home in Britain ... there are an awareness of AIDS all over the place ... We must teach people to be responsible about their behaviour ... I think that the government has a responsibility. Everyone in this country is tax paying citizens and the government I think has the responsibility because they are in the end going to sit with the financial cost - ultimately treating people in hospital. I think they should be the ones (must be) preventing the spread of the disease. I think the most effective way of doing it is possibly for the government to channel resources to those areas where people are effectively doing something about it ... In this country I don't think that you have got anybody on the AIDS Advisory Group that is gay. Not that that necessarily is a qualification for sitting on that Board, but I think that you have got to have people who are trained in the human element. We sit there with a lot of scientists and a lot of medical people. While they may be experts in their medical field, they get lost between that and the social side of things. I think we also need sociologists, social workers, psychologists invited in those areas (Interview with L.: 1988-02-09).

A voluntary service organization's managing and curbing of the AIDS problem

As indicated above, the gay community provides support services to AIDS patients and people who have tested HIV positive. The support services provided by a voluntary group, GASA-6010, will be discussed below.

The support services of GASA-6010 include the following:

a) Twenty-four-hour telephone counselling service

This service is provided by 25 lay counsellors who have undergone a 14-week training course and who work under the supervision of professional counsellors. This team is very skilled at dealing with all gay-related problems and those which cannot or should not be dealt with telephonically are referred to the clinic.

b) Counselling Clinic

A counselling clinic manned by professional counsellors is held twice a week. The clinic deals with the full spectrum of gay concerns including loneliness, "coming out" relationship problems, information on AIDS and the prevention of AIDS, etc. The counselling service has recently experienced a major influx of persons diagnosed as HIV positive or as having AIDS or an AIDS-related disease. The result is that AIDS-related problems have become the major concern of the clinic. AIDS services are provided to all persons irrespective of their sexual orientation.

c) AIDS Action Group

This group monitors AIDS research, liaises with health care providers in the interests of clients and promotes the Safer Sex Campaign among the general public and the visible gay community. The campaign consists of public addresses, the showing of relevant videos and the publication of safer sex pamphlets which are distributed every month at all known gay commercial venues in Cape Town. The members comprise well-educated professional people (mainly in the medical field).

d) AIDS Service Group

Members of this group befriend and assist persons with AIDS or AIDS-related diseases by helping with transport, shopping, banking, household chores, drives and outings. Referrals to this group are made by the counsellors.

e) HIV positive Support Team

Where appropriate and at the discretion of the counsellor concerned, HIV AB+ persons are referred to a member of the HIV AB+ support team, which consists of persons who are themselves positive, for shared experience and support. This is usually very beneficial and helpful during the days and first weeks following

diagnosis of HIV AB+ status.

f) HIV positive Support Group

This is a social as opposed to a therapy group where persons who are HIV AB+ get together on a regular basis. Referral is via the counsellor concerned or a member of the HIV positive support team.

During an interview with the Director of GASA-6010's counselling service it was stressed that the services provided rested on two fundamental concepts, namely **self-help** and the use of **trained volunteers**. The main element of teaching counselling skills to the layman is to train such a person to do telephone counselling in such a way that he can recognize a problem that he cannot deal with himself and refer it to a professional counsellor.

Two major problems confronting the service are finance and protecting the right to confidentiality of HIV and AB+ persons and AIDS sufferers. The importance of keeping these persons' identity a secret is illustrated by the following excerpt:

> I don't know if you read the newspaper reports but there was a teacher in Cape Town who had been diagnosed as having AIDS and there was a whole scandal to do with the school because we thought the newspaper was wrong in publishing the information in the first place. The Department of Education went into a total flat spin about whether this person should be fired, how his pension would be affected, his housing and such were the moral-ethical questions that came up, the problem at the school, the hysterical parents, etc. etc. Then all the medical issues and his lover having to deal with all that plus the hospital plus the medicine issues, first they put him on AZT and then taken off it. So it becomes an emotional roller-coaster ... (Interview with L.: 1988-02-09).

INFORMATION OBTAINED FROM PERSONAL DOCUMENTS[1]

Aspects of gays' innermost feelings regarding AIDS are given in the following excerpts from documents used in the study:

AIDS, high-risk groups and homosexuality

> ... With an epidemiological pattern fast following that of Africa, we in South Africa cannot afford to carry on a glib association of AIDS with homosexuality. The issue of high-risk groups is highly irrelevant when one considers that millions are to die of AIDS before any medical intervention becomes effective ... I must also stress that although I am ... sexually inactive, I may be living through the peak of the disease in the next 50 years. I do not intend to isolate myself from others and regardless of how careful I may be, I do consider anyone who escapes the syndrome over the next 50 years **very lucky**. It is quite conceivable that even I will die of AIDS. Therefore I concern myself with the politics of homosexuality and not with AIDS. Although I am a tremendously cautious person, I think that AIDS will constitute a treat to the political aims of gay people and will be used against us ...

Impact of AIDS on gays' psychosexual adaptation

> Nou sal baie mense seker sê: "Maar hoekom verander jy nie jouself nie?" Dis nie so maklik nie - dit is al so diep ingewortel - dis jou persoonlikheid, jou hele wese! Ook daarom dat ek twyfel of sielkundiges/psigiaters 'n mens sal kan verander. Dit is beslis nie 'n kwessie van, soos ek al so

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1 Personal documents refer to life histories, first-person accounts, letters, newspaper reports, brochures, etc. that provide evidence concerning the subjective viewpoint of the particular respondent.

baie mense hoor sê het "It's all in the mind" nie ...

I have no control over my sexual desires at all. I have spent a lot of money seeing a psychiatrist. I have been convicted of sexual crimes and been put in prison (where I really became a whore). The psychiatrist concluded that I have a very severe personality defect in the psychosexual field of my mind which came about by being raped by a stranger at the age of eight (I did not try to stop him as I didn't realize what he was actually doing). I was then seduced many times between the ages of 8 and 11 by an older family member. I then began to rent (prostitute) from the age of 12 and have continued to do so ever since. I realize that I have a very good chance of getting AIDS and if it does happen I will certainly die but I simply cannot stop being the whore and slut that I am.

Impact of AIDS in the work environment and on gays' self-acceptance

In February last year (1987) I was the victim of a bogus "Dr Botha" who phoned my employer and said that from "tests" conducted at the ... hospital in ..., I was AIDS positive. He ("Dr Botha") was phoning my boss to report that I was a danger to fellow employees - that I refused to undergo any treatment and had refused to co-operate with the medical authorities.

It is now a condition of my employment that I produce "negative AIDS tests" every four months. It the test showed positive I would be dismissed immediately - and here is my employer's rationale: "AIDS is a **self-inflicted** condition" (how illogical - if one contracts VD or is an alcoholic (both sicknesses) - does society say these are "self inflicted"? (Letter dated 17 March 1988).

"Safer sex"

Great sex! Don't let AIDS stop it. There's no need to freak

out about AIDS - simply join in the fashion for safe steamy passion. If you care about your life and loving, you'll ensure that safe play becomes the only way for you to enjoy intimate physical contact. Next time you're with someone special: don't come in your partner's mouth or allow him to come in yours. And if you enjoy sexual intercourse make sure that a condom is used together with a water-soluble lubricant, such as KY. Handcreams, vaseline and other exotic liquids are out. They may be a turn-on, but they'll ruin your condom as well as your safer sex life.

Affection is our best protection. Remember ... Great Sex is Healthy Sex!

(Brochure distributed by GASA-6010 AIDS Action Group.)

SAFE SEX PRACTICES	*UNSAFE SEX PRACTICES*
Massage, hugging, mutual masturbation, social kissing (dry), body-to-body rubbing (frontage), voyeurism, exhibitionism, fantasy	*Rimming, fisting, blood contact, sharing sex toys or needles, semen or urine in mouth, anal intercourse WITHOUT condom, vaginal intercourse WITHOUT condom.*

Prevent AIDS. Don't bend for a friend.

(*GANT*: Official newsletter of the GAY ASSOCIATION OF NORTHERN TRANSVAAL, Sept. 1987.)

DATA OBTAINED BY MEANS OF PARTICIPANT OBSERVATION AND FOCUS GROUPS

The most important insights gained from participant observation and focus groups were the following:

Prostitution scene

Ek (second author) het ongeveer om 22h00 die aand (1988-

01-22) na die berugte park in die stad (Kaapstad) gery. Daar was heelwat motors wat beweeg het en mense wat in die strate geloop het. Hoewel dit moeilik was om te bepaal wie van die mans in die een betrokke straat in dié omgewing hulself wou "uitverhuur", was daar tussen vyf en agt wat vir my verdag voorgekom het. Ek het besluit om om die blok te "cruise" en te kyk wat gebeur. Ek het so gemaak en 'n jong seun met 'n rooi hemp aan, het my genader. Hy wou weet of ek "in die scène is". Ek het instemmend geantwoord waarop hy gesê het dat hy enigiets vir my kon doen. Op my vraag: "Wat?" het hy gesê: "The best blow-job in town". ... Daar is minstens twee tipes persone op die rent-scène te wete "uitskuilers" ... en "ware rents". "Uitskuilers" probeer om die kliënte te beroof. Hulle beskou hulself nie as homoseksueel nie. Hulle probeer ook (om sover moontlik) nie met die klant te verkeer nie. Hulle sal egter, indien hulle verplig is om dienste te verrig, hoogstens tot "hand jobs" bereid wees ... Manlike prostitute is uiteraard 'n hoë VIGS-risikogroep en verdere subjekte binne dié groep sal beslis gewerf moet word ... (Fieldnote 1988-01-22).

People at risk of contracting HIV infection

Gays se persepsie van wat 'n hoë risikogroep is varieer. Dit is baie moontlik dat dié definisie mag verskil van dié wat in die media aangetref word. Hieruit volg dat iemand wat nie tot die geledere van die hoë risikogroepe behoort nie steeds hoë risiko-seksspraktyke mag hê. Gevolglik (sal) ... sulke mense nie hul gedrag verander nie ... Hoë VIGS-risikogroepe (is):

(a) biseksuele mans wat ook dikwels getroud is;
(b) gay-mans wat losse verhoudings aanknoop;
(c) rents (prostitute);
(d) gay-mans wat "gevaarlike" seks beoefen en
(e) gay-mans wie se verhoudings op die rotse beland

(Fieldnote 1988-02-05).

Stigmatization of HIV positive gays, AIDS sufferers and of persons using condoms

> Daar is min twyfel dat gays voel hulle word verantwoordelik gehou vir die siekte en dat daar teen VIGS-pasiënte gediskrimineer word. Die media gee baie sensasionele en negatiewe beriggewing in dié verband ... Kondome en die in-besit-wees daarvan word dikwels gesien as 'n bewys dat 'n persoon VIGS het en die gevolglike reaksies is dikwels stigmatiserend ... 'n Gay-man mag vrees dat sy manlikheid (deur sy seksmaat) bevraagteken mag word as hy daarop aandring dat 'n kondoom gebruik moet word ... (Fieldnote 1988-02-05).
>
> Dit is duidelik dat gays wat HIV positief is oorwegend skepties staan teenoor die belofte dat hul name vertroulik hanteer sal word (Fieldnote 1988-04-30).

Modifying factors that may have influenced the respondents' decision to take preventive action in order to reduce or eliminate the risk of contracting AIDS

Several important rationalizations were revealed (mainly through group focus interviews), including the following:

- Responses revealed a relation between reasons for being gay and decisions to practise safer sex or not. Subjects who believed they had **no control** over their sexual orientation, e.g. *I was born that way, there is nothing I can do to change myself*, were less motivated to change high-risk behaviour than those who believed their being gay was a personal choice.
- Some subjects tended to deny that they were at risk in respect of contracting AIDS through high-risk sexual behaviour, by using neutralization arguments such as: *I am a very healthy person and as long as I exercise regularly, eat nutritiously and get enough rest, I will not get AIDS.*
- "Coming out" may be a crucial stage in the transmission of HIV infection. The subject may be so involved in discovering his/her

own identity that the possibility of contracting AIDS is perceived to be non-existent. As one of the group members explained: *Man ek dink nie eers aan VIGS nie. Ek is op die oomblik soos 'n kind in 'n lekkergoedwinkel ek wil net vat en vat ...* (Fieldnote 1988-02-05).

- The period following the breaking up of a steady relationship seems to have important implications for the individual's decision to practise "safer sex". One of the subjects, who had had a relationship for several years, told the researchers: *Ek spring nie met enigeen in die bed nie, maar mens het 'n seksbehoefte. Nadat ek en ... uitmekaar is was dit moeilik, as jy nie anders kan nie vat jy later maar wat jy kan kry ... Mense wat lank in 'n verhouding was is meer kwesbaar. Nie alleen is jy depressief en kan nie omgee wat met jou gebeur nie, maar jy het ook nooit van veiliger seksmetodes geleer nie, weet nie hoe om dit toe te pas nie omdat jy mos nou tevore net een maat gehad het en nie 'n risiko was nie* (Conversation with gay male 1988-02-05).
- Two factors were identified that may influence behaviour even if the people involved are determined to take preventive action in order not to contract AIDS, namely lack of sexual control and being under the influence of alcohol. As one of the subjects stated: *As jy 'n "bliss nommer" sien, vergeet jy heeltemal van kondome; net so as jy dronk is ...* (Fieldnote 1988-02-08).

CONCLUSION

Important dimensions of the social impact of AIDS on South African gays are illustrated in the views quoted above; they provide valuable insight into the much neglected **human** side of AIDS. More specifically, a measure of understanding of and appreciation for the innermost feelings of a group of people who are generally considered "deviant", "sick", "carriers of the gay plague", etc. can be gleaned from the verbatim words and expressions of the subjects.

4

INTERPRETATION OF RESEARCH FINDINGS

INTRODUCTION

Before discussing any of the findings it should be noted that because of the biased nature of the "sample", the lay perceptions encountered in this study allow only limited generalization. Furthermore, any individual's construction of a health belief model is influenced by self-esteem, culture, formal education and media exposure (Bolognone & Johnson 1986:212). The large proportion of well-educated, reasonably affluent white male respondents who tended to be fairly overt regarding their sexual orientation, can be regarded as a limiting factor in the present exploratory study.

It would therefore be inappropriate and naive to draw final conclusions or make generalizations on the basis of the following findings.

DISCUSSION

The most pertinent findings include the following:

- The largest single group of the respondents (40,1%) indicated that they had had their first sexual experience at a relatively young age (between the ages of 11 and 16). It is generally agreed that young people should be provided with information on AIDS prior to becoming sexually active. This finding is of importance in view of the current controversy among social scientists regarding the age at which young people should receive AIDS education, and supports the view that education should be introduced at primary

school level "... so that children can grow up knowing the behaviour to avoid to protect themselves from exposure to the AIDS virus" (Koop 1986).

- The finding that some of the respondents kept their homosexual orientation a secret for a long time (sometimes never revealing it), has important implications for the AIDS epidemic in the RSA. If the majority of gays feel the need to hide their identity for fear of discrimination, it can be argued that gays will now, because of the added stigma of AIDS, be even less willing to accept and integrate their homosexual identity and associate themselves with a stigmatized high-risk group of people. The positive role models provided by gay leaders and organizations, the support of their own people, as well as learning about safer sex and developing positive attitudes towards it, will thus not be available to them.

- An important aspect of gay relationships came to the fore, namely that some respondents who were involved in steady relationships with one partner also engaged in short-term impersonal sexual encounters.

- Although 87,3% of the respondents indicated that a steady relationship was important or very important to them, 52,4% stated that they were not involved in such a relationship. A possible reason for this emerges from the qualitative data, namely that for a gay person to involve himself or herself in a steady relationship "is a loud social statement" which can be made only after reaching the stage of identity formation where he or she is ready to commit himself or herself to gay life. Warren (1974), Troiden (1977) and Schurink and Schurink (1982) found that taking a lover is the beginning of this final phase of gay identity formation, namely commitment. Despite a marked increase in community and peer pressure within the local gay community for men to form couples, the fusion of gay sexuality and emotion into a meaningful relationship can only be promoted in a less discriminating and rejecting society (Pegge 1988:45). The fact that homosexual relationships continue to be publicly condemned, despite being legalized in some foreign countries, may therefore have important implications for the spread of AIDS.

- The largest single percentage (40,5%) of respondents indicated

that they had been involved in one to five short-term relationships. At first, this seems to present a positive picture of the rate at which the epidemic will spread in the local homosexual population (*cf. Epidemiological Comments*, September 1988). However, it should be noted that the number of sex partners may no longer be a consistent AIDS risk predictor. Once the prevalence of HIV infection increases in a population, few sex partners will be needed to encounter an HIV infected partner (Kelly & St. Lawrence 1988:21). A recent large-scale study of gay and bisexual men revealed that men who had had five or more "one-night stands" over a period of one year were 18 times more likely to become HIV infected than those who did not engage in high-risk sexual practices with multiple partners (Kingsley *et al.* 1987).

- In America the AIDS epidemic started at the time the homosexual revolution (which resulted from the oppression of the homosexual community) gained momentum. Homosexual men were "coming out" and gaining rights and acceptance in increasing numbers (Harowski 1987:299-306). Gay activists encouraged homosexuals to take advantage of this growing acceptance by breaking down sexual repressions and liberating gay sex. It was argued that public sex is a central part of gay male culture. As Altman (1982:80) stated: "The Meat Rack at Fire Island, the Rambles in Central Park, the piers at the end of Christopher Street, are part of our space and we have as much right to demand that they be protected as Irish-Americans have to close Fifth Avenue to traffic for the St. Patrick's Day Parade." It is important to note that before the onset of the AIDS pandemic, sex (with many different partners) was regarded as a symbol of manhood and desirability in the gay community. Faced by the mortal danger of the AIDS epidemic, many homosexual men now have to relearn certain patterns of sexual behaviour, and come to regard specific sexual practices, previously unquestioned or even highly valued, as no longer desirable or safe (Quadland & Shattls 1987:283). Since sexual behaviour is a complex and integral part of people's lives, attempts to change the sexual behaviour of great numbers of homosexual or bisexual men will obviously require a very sophisticated educational approach.
- Although few of the respondents reported engaging in sexual

activities with females, the findings of the present study support those of Kinsey *et al.* (1972) and Padian *et al.* (1987), namely that people do not necessarily remain homosexual or heterosexual all their lives.

- The findings clearly show that the AIDS scare is having a profound influence (sexual and emotional) on the gay male population. Not only did 71,1% of the gay men report that from time to time they worried about contracting AIDS, but significant percentages (49,8 to 72,2) indicated that they had changed their sexual behaviour because of AIDS. In reply to a further question, another 82 respondents confirmed that they had recently changed their sexual activities. Of these, 23,2% indicated that they had abstained, either because of the AIDS scare or because of impotency. Although abstinence from sex may seem to be the answer and the authorities sometimes even advise homosexuals to do so, the question arises whether such a drastic measure will be enduring, or whether it may contribute to tension and depression, leading to occasional relapses into high-risk behaviour (Quadland & Shattls 1987:277-297). From this finding an important hypothesis can be formulated, namely that fear may play a more important role than knowledge in a person's decision to take preventive action in order not to contract a disease. This finding supports the most important assumption of the Health Belief Model, namely that the perceived threat of a disease plays an important role in a person's decision to prevent a particular disease.

- In an attempt to ascertain the respondents' knowledge of AIDS, five components were used: definition, aetiology, transmission, high-risk groups and treatment. The respondents were generally well-informed on these topics, and even lesser known facts about AIDS, for example that the blood test is not immediately positive after contact with the HIV virus, were known by 81,6%. An alarming fact, however, is that a significant percentage (61,7%) did not know or disagreed with the statement that a water-based lubricant was the only safe ointment for use with condoms, since oil-based lubricants cause the material (latex) of which condoms are made to deteriorate and perish (Kelly & St. Lawrence 1988:42-43). Other important findings that could have far-reaching

implications for the spread of AIDS and health in general, were that less than half the respondents (45,8%) knew that French-kissing could be a means of transmitting the HIV virus, and that some respondents regarded douching before or after sex, and swallowing bleach after oral sex or injecting bleach into the rectum after anal sex, as sufficient means of protecting themselves from contracting AIDS.

- Sources of information on AIDS that are readily available and accessible may play a more important role in strategies to combat AIDS than sources that are regarded as reliable but not readily available. More than seven out of ten respondents stated that they had been influenced to change their sexual behaviour by easily accessible and readily available sources of information such as newspapers and magazine articles which were, interestingly enough, not regarded as particularly reliable by most of them.

- The importance of specific media geared to meet the needs of the gay target group and presented at its level seems to be evident, since more than nine out of ten respondents regarded their own newspaper, *Exit* , to be as reliable a source of information on AIDS as medical journals, and 72,1% stated that articles in *Exit* were the main factor in their decision to practise safer sex. This tendency is also evident when responses concerning the effectiveness of attempts to combat the spread of AIDS made by gay organizations and those made by the government are compared.

- Regarding the relation between the number of sources used to obtain information on AIDS and the level of knowledge of participants, it should be noted that the more sources that were used, the higher the level of knowledge was regarding this deadly disease. It should therefore be borne in mind that this particular sample of gay men, who tended to be sophisticated and well read, may be more knowledgeable on the subject of AIDS than a more representative sample of gays. An important hypothesis that may emerge from this finding is that the greater the extent to which information on AIDS is made easily accessible and constantly available to the general public, the higher their knowledge of AIDS will become.

- Substances that have been associated with AIDS in other studies (Kelly & St. Lawrence 1988:26) include the smoking of cigarettes or marijuana, the consumption of alcohol and inhaling nitrates (Poppers). The danger of cigarette smoking lies mainly in the associated health hazard of immune system impairment while that connected with other substances mainly concerns the narcotic effects of these substances. Ten per cent of the sample stated that they did not always take preventive measures before engaging in sexual activity because they were under the influence of narcotic substances. This was substantiated by the qualitative data.

- Regarding the danger of HIV infection, it is alarming that quite a number of the respondents who participated in receptive anal intercourse (38,8%) acknowledged bleeding after having had this type of sexual contact. This finding is supported by several other studies (cf. Kelly & St. Lawrence 1988:21-22) which revealed that anal intercourse was the strongest predictor of AIDS and HIV infection because the rectal membrane tears and the trauma that often accompanies such rupturing allows the semen-borne virus to enter the bloodstream.

- The respondents' replies to the question as to whether or not they could freely discuss AIDS, safer sex practices, venereal diseases and relationship problems with their doctors, have important implications for the understanding between doctor and patient in general, and for the prevention of AIDS specifically. The fact that a substantial number of the respondents indicated that they could freely discuss AIDS (64,4%) and safer sex practices (59,2%) with their doctors emphasizes the responsibility of health professionals to provide informed advice on the prevention of this disease (cf. Isaacs & Miller 1985:327-330). However, the fact that relatively large percentages of the respondents stated that they did not discuss these important issues with their doctors, suggests that doctors need to do much more regarding the provision of informed and concerned guidance to apprehensive and often stigmatized risk groups.

- There is medical evidence that the rate at which and the severity with which the immune system is affected by the HIV virus can be correlated with certain diseases and infections. The diseases most

commonly linked to the prevalence of AIDS in the homosexual population are Hepatitis A and B and venereal diseases. When the immune system has been disrupted by these illnesses prior to exposure to the HIV virus, it seems that the destructive effect is enhanced (Antonio 1986:44). The prevalence of these sexually transmitted diseases in this specific group of gay men was very low (see Tables 12 & 13) compared to that in foreign gay male populations where studies show that between 50 and 75% of gay men have had Hepatitis B, 30 to 50% have suffered from Hepatitis A and that over 50% of the reported cases of syphilis in the United States occur among homosexual men (Antonio 1986:45-54).

- While HIV antibody testing serves the useful purpose of screening the blood in blood banks, the testing of healthy individuals is a controversial subject that raises many ethical questions (Kelly & St. Lawrence 1988:79-80; Leukefeld & Fimbres 1987:21-22; Pierce & VanDeVeer 1988:140-149). The reasons advanced by respondents for their hesitancy in coming forward for HIV testing should be noted by public health officials. These reasons include the following: (a) not at risk to contract AIDS (33,9%); (b) scared about the results (15,4%); (c) do not know the procedures (14,3%) and (d) fear breach of confidentiality (13,4%). These findings confirm those of Kelly and St. Lawrence (1988:80) who state: "Fears of confidentiality breaches and subsequent discrimination, ostracism, or loss of rights if the person's positive antibody status became known represent a significant deterrent to voluntary testing for risk-group members and are not unrealistic concerns."

- The most important finding of this study, which has far-reaching implications for any strategy to combat the spread of AIDS, is that although this group of respondents generally had a high level of knowledge of AIDS, a substantial number of them continued to participate in dangerous sexual practices. This finding is supported by Kelly *et al.* (1987) who concluded that, at least as far as their sample was concerned, knowledge of the AIDS risk bore no significant relation to the frequency of high or lower risk sexual activity during the 12-month period of their research. While both Kelly *et al.*'s study and the present one demonstrated this finding with a sample of gay men, it is important to bear Kelly and St. Lawrence's (1988:48) statement in mind, namely that there is little

reason to suspect that different results would occur if sexually active heterosexuals (of a similar background) were studied.

- Possible explanations for the fact that some respondents (even with a high degree of knowledge) still participated in dangerous sexual behaviour may be gleaned from the reasons given for not taking precautions to avoid contracting AIDS, namely: "Couldn't care"; "It won't happen to me"; "Not scared"; "Heat of the moment/unplanned sexual act"; "Not at risk"; "Under the influence/reckless"; "AIDS is not an issue"; "You can't have the same enjoyment" and "Condoms are in short supply".

However it is the qualitative data that provide valuable insight into the psychosocial processes that occur in an individual before he takes steps to cope with this major health problem. We should therefore now turn to some of the subjects' **own** definitions, interpretations and innermost feelings in an attempt to make sense of their understanding of AIDS and the strategies they employ to cope with the threat of AIDS.

- The gay subjects used a variety of expressions to conceptualize AIDS and to organize their understanding of it. While the respondents' language in respect of AIDS was filled with confusing and even contradictory statements, two main themes stand out clearly in the data. The one centres on the **medical side** of AIDS as opposed to the **stigmatization** of the disease (cf. Plummer 1988), while the other can be linked to the **control** or **lack of control** experienced by individuals in their decision to take preventive action.

Most respondents were of the opinion that AIDS should be regarded as a medical problem (such as cancer) and that it should not be "moralized". According to the medical perspective AIDS is a disease located within the human body; it involved more specifically the breakdown of the immune system. Management and treatment of AIDS within this perspective includes:

(a) The prevention of AIDS by maintaining one's physical and psychological well-being, thus being "body positive".

(b) The medical care and emotional support extended to AIDS sufferers and HIV infected people.

(c) The extensive search for a cure or vaccine.

On the whole the gay community has responded favourably to AIDS as a medical problem by establishing community-based services in various metropolitan areas in the country. GASA-6010's AIDS services have provided the model in this regard.

In contrast to the medical perspective, the moral view of AIDS explains the disease through a language of sin and moral responsibility, stressing management by means of discrimination and segregation. The respondents tended to reject the stigmatization of the disease and pointed to various dangerous consequences that this view of AIDS entailed, namely:

(a) That persons belonging to risk groups (e.g. homosexual males) might believe that simply being members of these groups would inevitably mean that they would contract AIDS.

(b) That people who were not members of so-called high-risk groups (e.g. heterosexuals) might incorrectly feel protected from the HIV virus by virtue of their lifestyle.

(c) That AIDS sufferers or HIV infected individuals might be reluctant to come out into the open in order to receive support and or the necessary information on safer sex.

(d) That the "coming out" process of people with a homosexual orientation would be complicated by the added stigma stemming from the AIDS scare, thus causing them to resort to "one-night stands" or impersonal sex in public toilets.

(e) That there might be unwillingness to make use of safer sex methods such as condoms because the subject's partner might question his masculinity or think that he had AIDS.

- Some of the respondents believed that coping with AIDS was beyond their control since its origin lay in **external forces**. The view generally expressed was that they had no other choice but to resign themselves to the inevitable and the only solution was therefore a cure or vaccine. Attitudes that were expressed included the following: *" Everybody will get AIDS so what?"; "We all have to die anyway"; "I am born this way, I can't help being what I am"* and *"Getting AIDS is just part of the risks of being gay"*. Other respondents felt that although they generally had control over their lives, some matters were beyond their control.

The following response was representative of this view: *"I know that I am at high risk because I have continuous casual contacts (daily) with total strangers ... I understand the dangers to myself and every contact I have. Yet despite a very real death sentence, I cannot control myself ..."*

- A number of respondents felt that the management of the threat of AIDS depended on their **own decision** more than on that of external factors. The following are examples of typical responses: *"People in high-risk groups must be encouraged to lead healthy lifestyles, e.g.*:

  (a) regular exercise,
  (b) healthy food,
  (c) eliminate stress,
  (d) regular rest and sleep, etc.", and

  "... the general attitude towards AIDS is, not it can't but it won't happen to ME and so sex - hetero and homo - will continue to be indulged in regardless". Finally, a group of respondents explained that although they were determined always to take the necessary precautionary measures, circumstantial factors such as being drunk, not having a condom available and being overwhelmed by the presence of a "bliss number" (a very attractive man), sometimes prevented them from carrying out their good intentions.

- While the respondents' recommendations concerning ways of curbing the spread of AIDS in Southern Africa were many and varied, their suggestions reflected both the medical and moral models of AIDS. In general the suggestions based on the medical model were positive and practical, while those based on moral issues tended to be more emotional and even absurd. On the whole the recommendations centred on two main aspects of the problem, namely that those who were not infected should avoid becoming infected, and that those who were already infected should avoid infecting others. A few respondents pinpointed the main reason why this seemingly easy solution to the problem was unfeasible, namely the role that **human nature** plays. As one of the subjects stated: *"A very difficult question. I regard myself as an intelligent, well-informed and quite sensible person. I do not*

have many sexual contacts, but on the few occasions I did have, I did not even think about AIDS or practising safer sex. I have a vague feeling (totally wrong of course) that only rents (male prostitutes) or real loose persons are in danger of contracting the disease. I will be surprised if this is not a general attitude amongst the average gay population."

- It was evident that the AIDS scare was transforming the respondents' perceptions of sexuality. It appears that the three stances identified by Plummer (1988) were confirmed by the ways the respondents reorganized sexual meanings. The stances are:

  (a) The **traditionalists** who want a return to the values of monogamy and celibacy. Some subjects were of the opinion that "loose sex is a killer", that "one-night stands must be abandoned", that "abstinence must be encouraged", that "gays must be more conservative as far as sex practice is concerned - fall in love and live happily ever after like in the old days", and that "the ideal is to try loving the person for his person not because of his sexual abilities".

  (b) The **safer sexers** who invented a new language of sexual experience that promotes physical pleasure without exchanging body fluids. Two general themes were highlighted by these respondents. Some emphasized **safe** and distinguished between sexual practices that had a low, medium and high risk as far as contracting AIDS was concerned. Other respondents placed the emphasis on **sex with eroticism**. This was neatly summarized by the following remarks from two respondents: "have ... amazing sexual experiences while playing safe" and "romanticizing the condom".

  (c) The **fatalists**. A minority of the participants were unconcerned about AIDS, did not feel personally endangered, thought it could not happen to them, could not care and would, if they contracted AIDS, deliberately try to infect as many other gays as possible.

5
CONCLUSIONS AND GUIDELINES

CONCLUSIONS

The present study revealed some dimensions of the social-psychological impact of AIDS on the local gay community, thus providing insight into the much neglected **human** side of the disease. This concerned more specifically gay men's definitions, interpretations and understanding of AIDS, as well as strategies employed by individuals and the community to cope with the threat of this major health problem and the stigma attached to it.

The findings show that the impact of AIDS on the lives of the respondents was **varied**. The diverse reaction to AIDS confirms Kotarba and Lang's (1986:141) finding that the reactions of gay men to the threat of AIDS are as varied as the individuals who participated in their research. Although the local gay community has through its leaders and counsellors clearly mobilized itself to reduce the threat of AIDS through efforts such as the safer sex campaign and strategies to maintain physical and psychological well-being, it cannot be assumed that this shift in values is characteristic of all gay men.

The link between knowledge and behaviour change ignores the immense complexity of human behaviour. Recent research in other areas of health promotion challenges the contention that information **alone** will create the motivation to change risk behaviour. Patterns of cigarette smoking, alcohol and drug abuse, and cardiovascular fitness do not change substantially in a population when information regarding the risk factors is made available (McAlister 1984; Ockene & Camic 1985; Swain & Stekel 1981). Prevention of AIDS requires far-reaching changes in sexual behaviour because sexual behaviour is a complex and integral part of peoples' lives which cannot merely be eliminated as in the case of alcohol, drugs or cigarette smoking. Altering sexual behaviour patterns can thus be expected to be more problematic than effecting changes in other areas

of human behaviour and will require very sophisticated educational approaches.

The complex psychosocial processes evident in the respondents' decisions either to take preventive action or not, clearly resemble steps in the Health Belief Model and emphasize the importance of control. The findings indicate that a high level of knowledge of AIDS was not sufficient motivation for behavioural change among the test group of gay men, but that certain modifying dynamics of both an internal and external nature intervened and prevented the respondents from taking the necessary precautions (Quadland & Shattls 1987:280).

These dynamics included demographic (age, status), psychosocial (personality), supernatural (the will of God) and circumstantial factors (such as being under the influence of alcohol while having sex and unplanned sexual acts). The study revealed the complexity of the psychosocial processes involved in the individual's decision to take or not to take preventive action against contracting a disease. **However, because of the research's exploratory nature, the findings remain speculative and can serve only as a basis for further in-depth studies aimed at gaining a clearer understaanding of the layman's conception of AIDS and those social processes at work when people attempt to cope with the threat of this terminal disease.** More studies need to be undertaken on the usefulness of the concepts identified in this research in order to develop new cost-effective strategies for the prevention of AIDS in the Republic of South Africa.

Since a national AIDS policy is urgently required, an attempt will be made in conclusion to establish a few guidelines in this regard.

GUIDELINES FOR A COMPREHENSIVE STRATEGY TO CURB AIDS

"Demoralize" AIDS

AIDS should be addressed in the same manner as any other human disease and should not be seen as a moral issue linked to people's

behaviour and lifestyles. The disease should (like any other disease) be managed by means of medical care and social support and not by segregation, discrimination and rejection. It should be explained in terms of scientific facts and not in terms of sin, evil and moral responsibility. The moralistic view of AIDS has a negative influence on strategies to combat the spread of AIDS and places unnecessary barriers in the path of people who endeavour to address the AIDS problem in a direct manner:

- Because of the stigma attached to AIDS victims as being gay or promiscuous, people at risk (or people with AIDS-related problems) are scared to come out in the open to receive the necessary social support, treatment for AIDS-related diseases and information on safer sex methods.
- AIDS sufferers (and their families) are exposed to a double stigma, namely that of being labelled as gay, sinful or evil and also that of having a self-inflicted disease.
- Because of the media portrayal of AIDS sufferers as promiscuous people with low moral standards, people at risk may not perceive themselves as such. This false sense of security may lead to continued exposure and spread of the AIDS virus.

Multidisciplinary approach

Any strategy to curb the spread of AIDS in a co-ordinated manner requires a multidisciplinary team approach involving epidemiologists, virologists, statisticians, demographers, economists, legal specialists, political scientists, anthropologists, sociologists, social workers, city planners, media experts, etc. From the inception of the AIDS problem, educational strategies to combat the spread of AIDS have been dominated by the biomedical community. AIDS cannot be fully understood and curbed through a medical approach alone. Any comprehensive strategy requires the additional input of social scientists such as sociologists, anthropologists and psychologists in order to be effective. It is therefore of vital importance that they urgently join their biomedical colleagues in doing sociocultural and psychosocial research and in implementing counselling, health promotion and educational programmes for high-risk individuals. AIDS health care delivery and the impact of AIDS on target groups also needs to be evaluated.

Target groups

The complexity of providing effective countermeasures against AIDS is evident in a multi-ethnic society characterized by a diversity of cultures, languages, literacy levels, religious convictions, value systems, political perceptions and demographic distributions. Specific target groups therefore need to be identified for the purpose of education. The aim of an AIDS educational programme is to provide information in such a way that the implications of high-risk behaviour are realized and the individuals concerned then make responsible and safe decisions regarding the prevention of the spread of AIDS. Educational programmes concerning the aetiology, prevalence and transmission of the AIDS virus should accordingly be presented not only by a medical team but also by experts who have an intimate knowledge of the target group's values, norms, needs, sexual orientation, culture, etc. and who have established a relationship of trust with the group's members. It is of the utmost importance that information be presented on a level that the target group's members can understand and that allows for full understanding of and identification with the message received. Educational campaigns should thus be geared to meet the needs of specific target groups and not be aimed at society as a whole.

Individual perceptions of AIDS

Public attitudes towards AIDS and individual perceptions thereof are not shaped solely by the media's sensational reporting of the subject or by awareness and or educational campaigns, but also by individual beliefs on health matters. Research into the lay beliefs concerning HIV infection and AIDS of various target groups needs to be done on an ongoing basis in order to develop more effective intervention strategies and to adapt policies according to changing circumstances.

Role of medical practitioners and health care workers

Since the reliability of a source of information has a direct impact on the educator's powers of persuasion, the most reliable sources of information in the community should be used. The medical doctor was identified as

one such source in this investigation. It is therefore essential that all medical practitioners and other health care workers (including traditional healers) should be well-informed on the subject of AIDS and safer sex practices, as well as on the pros and cons of the AIDS test. It is recommended that the subject of AIDS and the basic counselling skills needed to assure patients and to counsel HIV positives and AIDS sufferers be incorporated into the basic training course of all general practitioners and health care workers. Special training courses on the medical and psychological aspects of AIDS should also be held on a regular basis for all medical practitioners and health care workers.

Role of companies and businesses

Companies should play a leading role in educating their employees and the general public on AIDS-related matters and should pool their resources to help meet the needs of community members and researchers who are endeavouring to address the AIDS problem. The recent establishment of the AIDS Foundation in Johannesburg serves as a good starting point to make business aware of what can happen to the work force over the next 10 years and what should be done to educate ignorant and illiterate or semi-literate workers (*Finance Week* 1989:14).

The role of black trade unions

Trade unions usually concern themselves with issues such as union organization, political and legal education, equal opportunities for workers, ethical issues and health and safety at work. With the entrance of AIDS in the ethical and political arena, trade unions felt obliged to respond on behalf of their members. Since trade unions may regard employers' management of this fatal disease as a violation of workers' rights, AIDS has become a key issue in trade union politics. Trade unions in general, have already taken the task upon themselves to see to it that employers react responsibly and to ensure that none of their members' human rights were violated by forced screening, discrimination, lack of confidentiality and scapegoating and, that AIDS sufferers were compensated adequately.

However, up to date the strategies of the black trade unions have been largely based on grassroot reaction to government and employers'

actions, rather than being of a creative nature, and no comprehensive strategy to combat AIDS amongst their own members has been developed yet. Black trade unions are in the unique position that they have the trust of workers as well as intimate knowledge of their lay perceptions and of the culture to which they belong. Both these characteristics are essential requirements for any educational campaign designed to combat the spread of this fatal disease. Yet black trade unions such as NUMSA (National Union of Metalworkers of South Africa) were not consulted in studies that have been carried out or on resulting strategies devised to cope with the problem.

If mistakes of the past are not to be repeated it is essential that management and the unions should co-ordinate their efforts to combat AIDS.

Legislation concerning AIDS

Legislation determines the framework of any policy, and the policy on AIDS is no exception. Unlike the position in the USA and certain other countries AIDS (but not HIV seropositivity) is listed in terms of the South African Public Health Act 63 of 1977, Section 32 as a communicable disease but not as a notifiable medical condition. Additional legal provision for compulsory medical examinations was made at the end of 1987. These regulations empower a medical officer of health, on suspicion of any person having a communicable disease, to instruct such a person to undergo a medical examination, including blood or other diagnostic tests, and, if necessary, treatment. Since the AIDS virus cannot be casually transmitted in the same manner as for instance, measles or meningitis, and since it cannot be transmitted only by AIDS sufferers - but also by HIV seropositive persons - there is some doubt as to whether it is the best strategy (for AIDS sufferers and the community) to designate AIDS as a communicable disease.[1]

The Medical Association of South Africa (MASA) initially recommended that AIDS should be made notifiable but then changed its policy because the international medical community regarded notification of AIDS as a

1 This strategy may also be counterproductive because it may arouse unnecessary fear on the part of AIDS victims that they may be put under quarantine to prevent the spread of AIDS.

coercive step that could be counterproductive, resulting in the reluctance of sufferers to come forward. A central problem surrounding AIDS-legislation is reconciling two conflicting responsibilities. On the one hand the rights of individuals have to be protected and on the other hand the public's health must be safeguarded. The history of the control of illnesses such as measles, smallpox and syphilis indicates that widespread voluntary and educated action from individuals and communities who believe themselves to be at risk is needed (Hummel *et al.* 1986:25).

Although confidentiality of information is a crucial factor in any effort to combat the spread of AIDS, a situation where unidentified laboratory tests are the only source of epidemiological information is unacceptable (Ijsselmuiden *et al.* 1988).

Information on the spread of the HTLV-111 virus that causes AIDS is urgently required in South Africa. Such information need not include personal identification of HIV seropositively diagnosed people - merely their sociodemographic characteristics enabling epidemiologists to maintain a data bank for research purposes. This information would help researchers identify certain variables that seropositive persons have in common. Research could then be done on the reasons for certain tendencies, and in the process the "puzzle" of AIDS could be built up into a more complete and understandable picture. It is therefore recommended that all legislation regarding the reporting of AIDS should be urgently investigated by a multidisciplinary research team.

Requirements for a comprehensive educational campaign

Any AIDS educational campaign should meet the following requirements:

- It should be designed to meet the needs of specific target groups and it should be presented on an interpersonal level.
- There should be a relationship of trust between the educator and his audience to ensure maximum co-operation and effective learning on the part of the target group.
- AIDS educators should not only be experts in their fields; they should also have intimate knowledge of various target groups' cultural differences, sociodemographic characteristics and be

aware of modifying dynamics identified in the research such as psychosocial, supernatural, structural, circumstantial and cultural factors that may influence the target group's lay perception of AIDS.

- Innovative educational stategies are needed to combat the spread of AIDS. A combination of printed materials and interpersonal discussions, videos, personal contact with AIDS sufferers, etc. should be used. Global co-operation to devise effective educational strategies should be encouraged.
- The effectiveness of educational strategies should be monitored by multidisciplinary research. Both summative and formative evaluation of all educational material is necessary.
- Any strategy aimed at education on AIDS should be explicit, honest, non-judgemental and sufficiently funded. The message should also be consistently repeated, precise and uniform.

Co-ordination between statutory, private and voluntary social welfare, health services and researchers

The findings of this study suggest that a cost-effective strategy for combating AIDS should not be based solely on the traditional medical or professional health and welfare model. This model should be supplemented by a lay-oriented health care model. Government health policy should therefore recognize the importance of lay health care and should provide funds for the establishment of a national health body which should have the following functions:

- Promote the idea of self help among the public. Lay people who are concerned about the AIDS problem and professionals dealing with it should be informed about the advantages of self-help groups and the utilization of trained volunteers.
- Advise and support interested people (lay and professional) to set up self-help organizations and groups.
- Co-ordinate self-help community-based services on a national scale.
- Monitor and evaluate the effectiveness of services provided by

community-based organizations or groups.

- Stimulate and co-ordinate research on the social and psychological aspects of AIDS.
- Be a source of information to the public on AIDS and AIDS-related issues.
- Monitor local responses to government measures to combat the spread of AIDS.
- Subsidize voluntary organizations and groups that adhere to specific standards of service.

Community-based counselling and educational services

Findings of the present study suggest that the most cost-effective strategy to combat AIDS would be to establish a network of voluntary organizations based on the model of those organizations established by the Gay Men's Health Crisis in New York, Shanti in San Francisco and GASA-6010 in Cape Town.

Such voluntary community-based organizations should utilize trained volunteers and at the same time encourage self help. The following services should be provided:

(a) A 24-hour telephone counselling service manned by lay counsellors trained and supervised by professional counsellors (social workers) to deal with all AIDS-related matters and to refer AIDS sufferers and HIV infected people for professional help.

(b) A professional counselling clinic run on a weekly or daily basis.

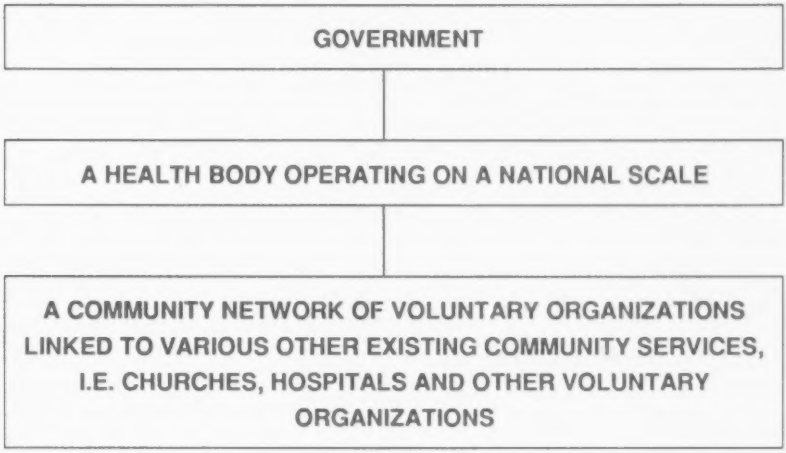
(c) A self-help group consisting of HIV infected people supervised by a social worker. The value of this type of group is that it is based on the shared experiences and mutual support of people with the same problem.

(d) A service group whose task it is to befriend and assist persons with AIDS or an AIDS-related illness and to help them with transport, shopping, household chores, etc. and to take them on regular outings.

(e) A day care centre for AIDS patients where they can receive all the necessary professional services from doctors, nurses and social workers and be occupied in a meaningful and financially worthwile manner in order to be as self-sufficient as possible.

(f) Multidisciplinary AIDS action groups that include members of target groups. These groups will have the following tasks: To make the general public aware of AIDS-related matters and launch a safer sex campaign among target groups; co-ordinate services for AIDS sufferers and their families; monitor the effectiveness of services provided by community-based organizations; monitor local changes and responses to government measures and report on these and special needs directly to a national health body.

The community-based network of services to combat AIDS cost-effectively can be presented schematically as follows:



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APPENDIX A : TABLES

TABLE 1 : CHARACTERISTICS OF THE RESPONDENTS

Characteristics	Responses	
	%	N
Age		
16-19 years	2,7	26
20-24 years	16,3	158
25-29 years	19,6	190
30-34 years	19,6	190
35-39 years	14,7	144
40-44 years	10,8	105
45-49 years	6,4	62
50-54 years	4,2	41
55-59 years	2,4	23
60-64 years	2,0	18
65 years and older	1,2	12
TOTAL*	100,0	969

TABLE 1 (continued)

Characteristics	**Responses**	
	%	**N**
Population group		
Caucasian European white	94,9	895
Other e.g. Chinese, coloured, Asian, black	5,0	48
TOTAL	100,0	1 000
Home language		
English	53,3	530
Afrikaans	32,2	320
English and Afrikaans	11,5	114
Other (e.g. Zulu; Sotho; Dutch; Portuguese; Yiddish; Swazi; Tamil; Urdu)	3,0	30
TOTAL	100,0	994

TABLE 1 (continued)

Characteristics	Responses	
	%	N
Population group		
Highest educational qualification		
Std 6/Form I	0,2	2
Std 7/Form II	1,2	12
Std 8/Form III	4,5	45
Std 9/Form IV	4,3	43
Std 10/Form V or equivalent (e.g. NTC III)	25,4	254
Std 10 plus 1 or 2 years' further training (e.g. NTC IV/V; GTC I/II)	13,9	139
Std 10 plus 3 years' further training (e.g. B.A.)	18,3	183
Std 10 plus 4 or more years' further training (e.g. M.Sc.; B.A. (H.E.D.); B.Arch.)	32,2	322
TOTAL	100,0	1 000
Legal marital status		
Never married	88,9	873
Married and living with spouse	2,9	28
Married but separated from spouse	0,8	8
Divorced	6,9	68
Widowed	0,5	5
TOTAL	100,0	982

TABLE 1 (continued)

Characteristics		Responses	
		%	N
Position in labour market			
Economically active	Employed full time (30 hours or more per week) by an organization	72,7	727
	Employed part time (less than 30 hours per week) by an organization	2,5	25
	Self-employed full time (30 hours or more per week)	12,0	120
	Self-employed part time (less than 30 hours per week)	1,2	12
	Student	7,0	70
	Unemployed and/or looking for work	2,3	23

TABLE 1 (continued)

Characteristics		Responses	
		%	N
Economically inactive	Retired/pensioner	2,3	23
	Unfit for employment	-	-
	Unemployed and not looking for work/running the household	-	-
TOTAL		100,0	1 000
Present occupation			
Professional (e.g. advocate; chartered accountant; physician; architect; quantity surveyor; pharmacist; veterinary surgeon)		11,2	97
Professional (e.g. natural or human scientist; teacher; minister; magistrate; artist; author; draftsman; medical auxiliary officer; social worker)		28,6	247

TABLE 1 (continued)

Characteristics	Responses	
	%	N
Administrative, executive and managerial work (e.g. director; working owner; senior public service employee (R26 000 + per annum))	23,4	202
Clerical work (e.g. clerk; bookkeeper; cashier; accountant; junior public service employee)	14,6	126
Sales work (e.g. insurance and estate agent; commercial traveller; shop assistant)	5,7	49
Farming and fishing (farmer; farm manager; forester; sorter and grader)	0,7	6
Mine, quarry and related work (e.g. mine captain; miner; shift boss; shaft worker; digger; reduction worker; quarry worker)	0,3	3
Transport and communication work (e.g. engine/taxi/lorry driver; navigator; conductor; telephonist; radio operator; fireman)	1,2	10

TABLE 1 (continued)

Characteristics	Responses	
	%	N
Skilled artisan's work (e.g. painter; bricklayer; electrician; plumber)	3,2	28
Semiskilled and unskilled work (e.g. operator; apprentice; labourer)	1,0	9
Service work (police, prisons and defence force employee)	2,3	20
Other service work (e.g. waiter; professional sportsman; guide; political organizer; entertainment worker; hair-dresser; funeral undertaker; caretaker)	7,9	68
TOTAL**	100,0	865

TABLE 1 (continued)

Characteristics	Responses	
	%	N
Total monthly income (before deductions)		
R249 or less	4,7	45
R250-R499	2,8	27
R500-R749	2,4	23
R750-R999	4,1	39
R1 000-R1 249	6,6	63
R1 250-R1 499	9,1	86
R1 500-R1 999	13,7	130
R2 000-R2 499	12,6	120
R2 500-R2 999	12,5	119
R3 000-R3 999	13,6	129
R4 000-R4 999	8,7	83
R5 000 or more	9,1	86
TOTAL	100,0	950

TABLE 1 (continued)

Characteristics	Responses	
	%	N
Province/geographical area		
Cape	21,1	210
Natal	14,0	139
Transvaal	60,7	603
Orange Free State	2,1	21
Other (e.g. SWA/Namibia; Swaziland; Zimbabwe; Ciskei; London)	2,0	20
TOTAL	100,0	993
Place of residence		
City	83,0	820
Town	14,2	140
Farm	2,8	28
TOTAL	100,0	988

TABLE 1 (continued)

Characteristics	Responses	
	%	N
Type of housing		
House	47,9	474
Townhouse/simplex flat	21,5	213
Flat in high-rise apartment block	24,7	245
Boarding house	1,2	12
University college/hostel	0,8	8
Other (e.g. duplex flat; YMCA apartment; barrack; army quarters; bungalow)	3,8	38
TOTAL	100,0	990
Living arrangements		
Lives - on his own	44,2	436
with parents	11,3	111
with other relatives	1,9	19
with lover	27,0	266
with a gay friend (not lover)	7,3	72
with a straight friend	1,3	13
in a commune (gay, straight or mixed)	1,9	19
in a hotel/hostel/boarding house/barrack with spouse	1,8	18

TABLE 1 (continued)

Characteristics	Responses	
	%	N
with spouse in a straight marriage	2,6	26
with other (e.g. transsexual marriage; lover and child(ren))	0,6	6
TOTAL	100,0	986
Church/denomination		
None	24,2	241
Atheist	4,9	49
Roman Catholic	11,0	110
Protestant (e.g. Methodist; Presbyterian; Dutch Reformed; Lutheran; Anglican)	45,1	449
Oriental religion (e.g. Buddhism; Islam; Hinduism, Hari Krishna; Yoga)	2,2	22
Jewish	2,8	28
Other Christian churches (e.g. Seventh Day Adventists; Quakers; Salvation Army; Pentecostal; Mormon)	6,3	63
Interdenominational (e.g. Rhema; Christian Centre; Gay Christian Community)	0,9	9
Other (e.g. Suti; Cot Pof Africa; Lamaison; Transcendental; Spiritual)	2,5	25
TOTAL	100,0	996

TABLE 1 (continued)

Characteristics	Responses	
	%	N
Overtness/covertness		
1 Not out of the closet at all	9,6	90
2	13,6	128
3 Neither in nor out of the closet	22,8	214
4	26,4	248
5 Out of the closet to a very great extent	27,6	259
TOTAL	100,0	939
Importance of gay community to respondents		
1 (Very unimportant)	12,1	118
2	14,0	137
3	26,4	258
4	22,9	224
5 (Very important)	24,7	242
TOTAL	100,0	979

TABLE 1 (continued)

Characteristics	Responses	
	%	N
Length of time after having defined self as gay before letting others know about it		
N.a.- Have not come out yet to anyone	5,1	49
The same day or within the same week	11,4	110
After 1 week to 3 months	12,7	123
After 3 to 6 months	7,9	76
After 7 months to 2 years	22,0	213
After 2 to 5 years	20,7	200
After 5 to 10 years	12,0	116
After more than 10 years	8,3	80
TOTAL	100,0	967

* Owing to rounding the percentage totals do not always add up to 100,0 but vary between 99,9 and 100,1. Because all the respondents did not answer all the questions, the frequency totals vary from one question to the next.

** Only respondents who were economically active at the time of the study are included in this table.

*** It was, of course, not possible to ascertain the population group of these respondents.

TABLE 2 : PERSON WITH WHOM RESPONDENTS HAD THEIR FIRST SEXUAL EXPERIENCE

Person	Responses	
	%	N
Peer (school friend of same age)	3,7	36
Friend	65,8	641
Older anonymous man	1,6	16
Person in position of trust (teacher/minister/policeman)	1,4	14
Heterosexual experience (with wife, girlfriend, colleague, etc.)	2,1	20
Cousin/nephew	8,6	84
Brother/stepbrother	3,5	34
"Rentpiece"/prostitute, etc.	1,0	10
Present lover of the same sex	0,4	4
Uncle	1,1	11
Neighbour's son/daughter	1,0	10
Stranger	7,4	72
Other (e.g. servant; rape)	2,4	23
TOTAL	100,0	975

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TABLE 3 : SEXUAL ACTIVITIES: MALE WITH MALE

Activities	RESPONSES								
	Used a condom								
	Yes			No			NA		
	Activity increased	Activity decreased	Activity stayed the same	Activity increased	Activity decreased	Activity stayed the same	Did not participate in it	TOTAL*	
	%	%	%	%	%	%	%	%	N
Masturbation									
Active:									
Regular partner	1,4	0,9	3,3	6,7	9,2	35,0	43,6	100,0	872
Casual partner	1,8	2,5	2,9	8,1	13,6	24,0	47,1	100,0	889
Passive:									
Regular partner	1,3	0,7	1,9	4,1	7,0	26,3	58,7	100,0	898
Casual partner	1,2	1,7	1,8	6,2	11,2	17,6	60,3	100,0	903
Oral sex									
Active:									
Regular partner	1,4	2,1	3,1	8,7	10,8	28,6	45,3	100,0	871
Casual partner	1,5	3,0	3,4	4,4	15,4	16,0	56,4	100,0	890
Passive:									
Regular partner	0,8	1,8	2,1	5,4	9,3	22,5	58,2	100,0	894
Casual partner	0,5	2,6	2,3	3,7	12,6	14,4	63,8	100,0	917

TABLE 3 (continued)

Anal intercourse									
Active:									
Regular partner	2,3	3,5	6,3	5,7	7,5	15,5	59,1	100,0	915
Casual partner	1,6	7,8	6,5	2,2	7,6	5,4	68,8	100,0	937
Passive:									
Regular partner	1,5	3,4	5,1	4,5	7,7	10,7	67,1	100,0	924
Casual partner	1,2	6,4	4,5	1,7	6,3	4,2	75,6	100,0	928
Other (e.g. rimming; group sex; kinky sex; S + M; body rubbing; abstained due to AIDS scare; voyeurism									
Active:									
Regular partner	0,3	-	0,5	2,1	0,5	3,0	93,6	100,0	610
Casual partner	0,5	0,2	0,8	1,1	1,9	1,6	93,9	100,0	619
Passive:									
Regular partner	0,5	0,2	0,3	1,8	0,3	2,3	94,6	100,0	612
Casual partner	0,5	-	0,3	1,0	1,8	0,5	96,0	100,0	622

• Regarding each sexual activity a few respondents answered that the activity had either increased, decreased or stayed the same without indicating whether they had used a condom or not while participating in the activity. These respondents are excluded from this table.

TABLE 4 : KNOWLEDGE OF CERTAIN FACTS REGARDING AIDS

	Responses				
Facts	**True**	**False**	**Don't know**	**TOTAL**	
	%	**%**	**%**	**%**	**N**
AIDS is caused by a virus	93,4	4,1	2,5	100,0	975
There is a cure for AIDS	2,1	94,6	3,3	100,0	977
There is a vaccine against AIDS	5,3	89,0	5,6	100,0	977
AIDS may be contracted from blood and blood products	96,6	2,2	1,1	100,0	979
All blood donations are tested for AIDS	84,9	6,3	8,8	100,0	976
AIDS can be contracted from sharing washing, eating and drinking utensils	1,6	96,0	2,3	100,0	979
AIDS can be contracted by sharing needles and syringes	98,7	0,7	0,6	100,0	979
AIDS is transmitted principally by sexual intercourse between males	47,2	49,8	3,0	100,0	978
AIDS can only be transmitted by homosexual intercourse	7,9	91,0	1,1	100,0	978
Women are much less prone to AIDS	15,5	77,7	6,7	100,0	979
A woman who has AIDS cannot carry it over to her unborn child	5,3	92,7	2,0	100,0	980
If your blood test is positive (contains anti-bodies to the AIDS virus) you will die of AIDS	19,5	69,2	11,3	100,0	973

TABLE 4 (continued)

Facts	Responses			TOTAL	
	True	False	Don't know		
	%	%	%	%	N
French kissing is a safe practice regarding the spread of AIDS	32,3	45,8	21,9	100,0	974
If your blood test is positive (contains anti-bodies to the AIDS virus) you can spread AIDS	92,5	2,7	4,8	100,0	976
If your blood test is negative you need never worry again	3,9	92,6	3,5	100,0	979
All infected people show positive on the blood tests	26,4	57,8	15,8	100,0	997
The blood test is immediately positive if you have been in contact with AIDS	7,8	81,6	10,6	100,0	980
Names and addresses of AIDS carriers are kept on a register and are available to anyone	3,2	83,8	13,0	100,0	977
There is no confidentiality about AIDS tests	11,4	75,9	12,7	100,0	974
A water-based lubricant like KY jelly is the only lubricant considered safe when using condoms	38,3	33,9	27,8	100,0	977
Douching before having sex can prevent AIDS	2,6	79,8	17,7	100,0	968
Douching after having had sex can prevent AIDS	5,0	75,5	19,5	100,0	967

TABLE 5 : SEXUAL PRACTICES REGARDED AS SAFE*

Safe practices	Responses	
	%	N
Mutual masturbation with or without condom	26,7	246
Sex (unspecified) with condoms	19,7	182
One regular partner	11,9	110
Self-masturbation/Solo	12,5	115
Body-to-body rubbing/hugging/cuddling/petting	3,9	36
Kissing (dry)	3,6	33
Anal intercourse with condom	3,6	33
None totally safe/not many safe	3,1	29
Fellatio/oral sex/blow jobs	3,9	36
Other (e.g. French kissing; fisting; oral sex with condom; anal intercourse with a condom and water-based lubricant; oral sex before ejaculation; celibacy; avoiding contact with partner's semen, blood and saliva; active anal sex; reputation of partner)	11,1	102
TOTAL	100,0	922

* Respondents' answers to an unstructured question.

TABLE 6 : SEXUAL PRACTICES REGARDED AS UNSAFE*

Unsafe practices	Responses	
	%	N
Anal intercourse without a condom	10,6	96
Sex (unspecified) without a condom	13,8	125
Any sex involving exchange of body fluids	4,7	43
Most/all practices are unsafe	3,0	27
Promiscuity/many partners/casual sexual encounters	15,0	136
Oral sex/fellatio/blow jobs	10,8	98
Anal intercourse	30,1	273
Accepting semen in mouth during oral sex	4,3	39
Other (e.g. rimming; watersports; French kissing; blood contact during sex; receptive anal sex; petting; fisting; blood transfusions; sharing of needles; sharing of toothbrush)	7,8	71
TOTAL	100,0	908

* Respondents' answers to an unstructured question.

TABLE 7 : REASONS FOR NOT TAKING PRECAUTIONARY MEASURES* WHILE HAVING SEX DURING THE PAST YEAR: "YES" RESPONSES

Reasons	Responses	
	%	N
Have contracted AIDS already	2,1	288
Lacked adequate information/didn't know what measures to take	19,4	283
Had sex with one exclusive partner for more than 10 years	22,7	299
Couldn't care	12,6	277
Won't happen to me	13,2	273
Not scared	19,6	280

* According to 689 respondents, they did take precautionary measures or abstained during the specified period. These respondents are not included in this table.

TABLE 8 : REASONS FOR ESTIMATING GOVERNMENT EFFORTS TO COMBAT THE SPREAD OF AIDS AS INEFFECTIVE

Reasons	Responses	
	%	N
Insufficient/poor/vague/inaccurate information	23,8	86
A more open/direct/honest/approach is necessary	18,2	66
Risk groups are not targeted/shock tactics should be used	12,7	46
Lack of trust in government because of homophobic attitude	8,3	30
Information is not published widely enough	9,1	33
Too little knowledge is supplied/lack information on safe sexual practices	3,6	13
Insufficient efforts are aimed at the white heterosexual population who think they are safe anyway	4,4	16
Too difficult to change sexual behavioural patterns	3,0	11
Not enough is being done	6,6	24
A Calvinistic and prejudiced attitude is taken, confusing moral issues with AIDS	2,2	8
There are signs of apathy/efforts are too late	2,2	8
Other (e.g. other media should be utilized; too much money is spent on a poor effort; too surreptitious and directive; AIDS is incorrectly seen as mainly a gay disease)	5,8	21
TOTAL*	100,0	362

* Only respondents who indicated at a previous question that these efforts were ineffective are included in this table.

TABLE 9 : VIEWS ON MEANS WHICH CAN BE USED SUCCESSFULLY TO EDUCATE AND INFORM GAY PEOPLE ABOUT AIDS: "YES" RESPONSES

Means	Responses	
	%	N
Pamphlets	91,6	963
Radio	84,5	953
Television	94,0	970
Videos/films	88,9	955
Newspapers	89,9	958
Magazines	90,0	961
Posters/billboards	76,8	944
Gay counsellors	88,9	957
General practitioners (doctors)	89,4	954
Pharmacists	76,2	943
Family-planning clinics	75,5	944

TABLE 10 : INFLUENCE OF SPECIFIED FACTORS ON CHANGE IN SEXUAL BEHAVIOUR* IN ORDER NOT TO CONTRACT AIDS: "YES" RESPONSES

Factors	Responses	
	%	N
Learning that someone known to respondent has AIDS	42,8	726
Newspaper reports on AIDS	77,0	847
Articles in *Exit* on AIDS	72,1	828
Articles in magazines on AIDS	74,7	843
Lecture(s) on AIDS by authorities on the subject	45,6	785
Lectures/talks on AIDS by AIDS sufferers	38,7	772
Pamphlets on AIDS	75,9	831
Television programme(s) on AIDS	71,0	839
Own family doctor	30,8	777
A radio programme about AIDS	42,0	785
Gay counsellor(s)	22,6	760
Seeing photographs of AIDS victims	61,7	825
Videos/films about AIDS victims	54,9	799

* Various numbers of respondents indicated at each of the factors that they had not changed their sexual behaviour. These respondents are excluded from this table.

TABLE 11 : PERSONAL HABITS/CHARACTERISTICS OF RESPONDENTS: "YES" RESPONSES

Habits/characteristics	Responses	
	%	N
Regular participation in sport	33,2	987
Eating of three regular meals per day	51,1	989
Vegetarianism	6,8	985
Eating of much junk food	25,9	985
Using of non-prescription medicine more than three times per week	12,1	984
Regular taking of vitamins	44,6	987
Seeing doctor regularly for a check-up	46,2	987
Being overweight	24,7	986
Being underweight	10,9	965
Regularly used antibiotics in past six months	18,0	982

TABLE 12 : RESPONDENTS' AILMENTS (PAST AND PRESENT)

Ailments	Responses		Ailments	Responses	
	%	N		%	N
Diabetes mellitus (sugar disease)			**Thyroid disease**		
Don't know	2,0	20	Don't know	2,0	20
Yes, do suffer from it	0,8	8	Yes, do suffer from it	0,4	4
Yes, did suffer from it	0,4	4	Yes, did suffer from it	0,7	7
No	96,8	954	No	96,8	950
TOTAL	100,0	986	TOTAL	100,0	981
High blood pressure			**Heart problems**		
Don't know	2,8	28	Don't know	2,7	27
Yes, do suffer from it	6,5	64	Yes, do suffer from it	4,6	45
Yes, did suffer from it	6,6	65	Yes, did suffer from it	3,1	31
No	84,1	829	No	89,6	883
TOTAL	100,0	986	TOTAL	100,0	986
High blood cholesterol			**Unexpected weight loss**		
Don't know	7,1	70	Don't know	0,3	3
Yes, do suffer from it	3,9	38	Yes, do suffer from it	1,5	15
Yes, did suffer from it	3,0	30	Yes, did suffer from it	2,4	24
No	86,0	847	No	95,7	942
TOTAL	100,0	985	TOTAL	100,0	984

TABEL 12 (continued)

Ailments	Responses		Ailments	Responses	
	%	N		%	N
Shortness of breath and a dry cough			**Intermittent diarrhoea with no obvious cause**		
Don't know	0,6	6	Don't know	0,6	6
Yes, do suffer from it	5,1	50	Yes, do suffer from it	3,4	33
Yes, did suffer from it	4,6	45	Yes, did suffer from it	3,0	30
No	89,7	884	No	93,0	916
TOTAL	100,0	985	TOTAL	100,0985	
Profound fatigue			**Recurrent kidney/bladder infections**		
Don't know	1,5	15	Don't know	0,4	4
Yes, do suffer from it	5,4	53	Yes, do suffer from it	1,1	11
Yes, did suffer from it	4,7	46	Yes, did suffer from it	3,9	38
No	88,4	871	No	94,6	932
TOTAL	100,0	985	TOTAL	100,0	985
Recurrent lung infections			**Flu more than once a year**		
Don't know	0,7	7	Don't know	0,8	8
Yes, do suffer from it	1,6	16	Yes, do suffer from it	10,9	107
Yes, did suffer from it	1,8	18	Yes, did suffer from it	14,9	147
No	95,8	943	No	73,4	722
TOTAL	100,0	984	TOTAL	100,0	984

TABEL 12 (continued)

Ailments	Responses		Ailments	Responses	
	%	N		%	N
Hepatitis (jaundice) type A			**Hepatitis (jaundice) type B**		
Don't know	3,0	29	Don't know	2,5	24
Yes, do suffer from it	0,5	5	Yes, do suffer from it	0,6	6
Yes, did suffer from it	4,8	47	Yes, did suffer from it	6,1	60
No	91,7	895	No	90,8	887
TOTAL	100,0	976	TOTAL	100,0	977
Swollen glands (neck, armpits, groin)			**Fever and night sweats**		
Don't know	0,6	6	Don't know	0,2	2
Yes, do suffer from it	2,2	22	Yes, do suffer from it	3,0	30
Yes, did suffer from it	8,2	81	Yes, did suffer from it	5,0	49
No	88,9	876	No	91,8	903
TOTAL	100,0	985	TOTAL	100,0	984
Tuberculosis			**Recurrent skin infections (e.g. boils, acne)**		
Don't know	0,3	3	Don't know	0,2	2
Yes, do suffer from it	0,2	2	Yes, do suffer from it	7,8	77
Yes, did suffer from it	1,0	10	Yes, did suffer from it	10,4	102
No	98,5	970	No	81,6	804
TOTAL	100,0	985	TOTAL	100,0	985

TABEL 12 (continued)

Ailments	Responses		Ailments	Responses	
	%	N		%	N
Fungus infections			**Red or brown blotches looking like blisters on skin and/or inside mouth**		
Don't know	0,7	7	Don't know	0,4	4
Yes, do suffer from it	6,0	59	Yes, do suffer from it	1,3	13
Yes, did suffer from it	11,9	117	Yes, did suffer from it	1,3	13
No	81,4	799	No	97,0	954
TOTAL	100,0	982	TOTAL	100,0	984
Genital warts			**Crabs scabies**		
Don't know	0,2	2	Don't know	0,2	2
Yes, do suffer from it	1,1	11	Yes, do suffer from it	1,0	10
Yes, did suffer from it	5,8	57	Yes, did suffer from it	29,2	288
No	92,9	912	No	69,5	685
TOTAL	100,0	982	TOTAL	100,0	985

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TABLE 13 : RESPONDENTS WHO HAD SUFFERED FROM SPECIFIED INFECTIONS: "YES" RESPONSES

Infections	Responses	
	%	N
Infection of the testes	5,1	909
Infection of the prostate gland	8,0	904
Infection of the rectum (anus)	7,0	909
Syphilis	8,6	911
Gonorrhoea (clap)	21,7	923
Genital (venereal) warts	9,0	903
Herpes	5,4	902

TABLE 14 : FREQUENCY OF USAGE OF SPECIFIED SUBSTANCES

Substances	Responses		Substances	Responses	
	%	N		%	N
Alcohol			**Opium, morphine, heroin, codeine, wellcanol, pethedine (fix, herries, welkies, pinks, peths)**		
Have never used	5,1	50	Have never used	98,3	952
Used to take it but no longer do so	4,8	47	Used to take it but no longer do so	0,6	6
Daily	19,9	195	Daily	-	-
Once a week or more (but not daily)	42,2	413	Once a week or more (but not daily)	0,1	1
One to three times a month	17,4	170	One to three times a month	0,2	2
Every two to three months	3,4	33	Every two to three months	0,2	2
A few times a year	5,6	55	A few times a year	0,2	2
Once a year or less	1,6	16	Once a year or less	0,3	3
TOTAL	100,0	979	TOTAL	100,0	968

TABLE 14 (continued)

Substances	Responses		Substances	Responses	
	%	N		%	N
Luminal, seconal, vesperax, mandrax (goofballs, red devils, downers, whites)			**Valium, librium, A.P. cod (downers)**		
Have never used	95,3	922	Have never used	84,2	812
Used to take it but no longer do so	3,1	30	Used to take it but no longer do so	5,7	55
Daily	0,1	1	Daily	0,6	6
Once a week or more (but not daily)	0,1	1	Once a week or more (but not daily)	0,7	7
One to three times a month	0,1	1	One to three times a month	0,7	7
Every two to three months	0,2	2	Every two to three months	0,4	4
A few times a year	0,1	1	A few times a year	2,8	27
Once a year or less	0,1	1	Once a year or less	4,8	46
TOTAL	100,0	967	TOTAL	100,0	964
Poppers, benzine, glue, petrol			**Ritalin, dexedrine, benzedrine (dexies, benzines, ravers, speed, uppers)**		
Have never used	63,7	615	Have never used	95,5	915
Used to take it but no longer do so	12,1	117	Used to take it but no no longer do so	2,5	24
Daily	0,4	4	Daily	-	-
Once a week or more (but not daily)	1,7	16	Once a week or more (but not daily)	0,2	2
One to three times a month	4,1	40	One to three times a month	0,2	2
Every two to three months	1,8	17	Every two to three months	0,3	3
A few times a year	6,2	60	A few times a year	0,3	3
Once a year or less	10,0	97	Once a year or less	0,9	9
TOTAL	100,0	966	TOTAL	100,0	958

TABLE 14 (continued)

Substances	Responses		Substances	Responses	
	%	N		%	N
Obex, tenuate, ponderax, redupon (obies, yellows, speed, uppers)			**Cocaine, adrenaline, ephedrine, caffeine (snow, coke, shit)**		
Have never used	88,5	854	Have never used	95,4	923
Used to take it but no longer do so	6,2	60	Used to take it but no longer do so	1,7	16
Daily	0,2	2	Daily	0,4	4
Once a week or more (but not daily)	0,2	2	Once a week or more (but not daily)	0,1	1
One to three times a month	0,4	4	One to three times a month	0,1	1
Every two to three months	0,6	6	Every two to three months	0,1	1
A few times a year	1,5	14	A few times a year	0,5	5
Once a year or less	2,4	23	Once a year or less	1,7	16
TOTAL	100,0	965	TOTAL	100,0	967
Dagga (joint, pipe, poisons, grass, Mary Jane, zol, boom, skyf, pot, dope)			**LSD (acid, microdots, sunshine, candy, smarties)**		
Have never used	57,4	560	Have never used	95,0	915
Used to take it but no longer do so	11,6	113	Used to take it but no longer do so	2,1	20
Daily	1,5	15	Daily	-	-
Once a week or more (but not daily)	2,5	24	Once a week or more (but not daily)	-	-
One to three times a month	3,5	34	One to three times a month	0,1	1
Every two to three months	3,7	36	Every two to three months	0,1	1
A few times a year	6,7	65	A few times a year	0,6	6
Once a year or less	13,1	128	Once a year or less	2,1	20
TOTAL	100,0	975	TOTAL	100,0	963

TABLE 14 (continued)

Substances	Responses	
	%	N
Malpitte, artane, mescaline, magic mushroom, nutmeg (mecs, pitte, pearly gates, flying saucers, angel dust)		
Have never used	98,4	950
Used to take it but no longer do so	1,1	11
Daily	-	-
Once a week or more (but not daily)	-	-
One to three times a month	0,1	1
Every two to three months	-	-
A few times a year	-	-
Once a year or less	0,3	3
TOTAL	100,0	965

TABLE 15 : SMOKING OF CIGARETTES

Number of cigarettes	Responses	
	%	N
Have never smoked	35,4	351
Used to smoke, but stopped	20,3	201
Smoke less than 15 daily	11,8	117
Smoke between 16 and 26 daily	18,0	178
Smoke between 27 and 37 daily	9,6	95
Smoke between 38 and 48 daily	3,4	34
Smoke between 49 and 59 daily	1,2	12
Smoke between 60 and 80 daily	0,3	3
TOTAL	100,0	991

TABLE 16 : LEVEL OF KNOWLEDGE REGARDING AIDS-RELATED STATEMENTS

Number of statements answered correctly	Responses	
	%	N
1	-	-
2	0,1	1
3	0,1	1
4	-	-
5	0,1	1
6	0,4	4
7	0,3	3
8	0,1	1
9	0,6	6
10	0,5	5
11	1,2	12
12	2,7	26
13	3,8	37
14	4,3	42
15	4,6	45
16	7,7	75
17	12,4	121
18	18,1	177
19	19,6	192
20	15,5	152
21	6,8	67
22	1,1	11
TOTAL*	100,0	979

* Twenty-five respondents either did not give an answer at any of the statements or gave the wrong answer at all 22 statements. These respondents are excluded from this table.

TABLE 17 : UTILIZATION OF SOURCES OF INFORMATION ON AIDS

Number of sources utilized	Responses	
	%	N
1	0,9	9
2	4,1	40
3	6,2	61
4	11,6	113
5	19,4	189
6	18,0	176
7	15,1	147
8	12,7	124
9	6,2	61
10	3,8	37
11	2,0	19
TOTAL*	100,0	976

* The respondents (N = 28) who did not answer this question/had not gained their knowledge from any of these sources are excluded from this table.

Evanthe and Willem Schurink form an authoritative team to research and present a work such as this. These experienced researchers have been involved in extensive work on gay and deviant life styles and also AIDS.

Evanthe is involved in re-integration programmes as well as a crisis programme for rape victims. Willem is well versed with various facets of prison life and his research has covered socio- and criminology studies into prostitution, violence, sexual offences and subcultures such as alternative life styles.

This husband and wife team are authors and co-authors of a host of scientific articles and publications.

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